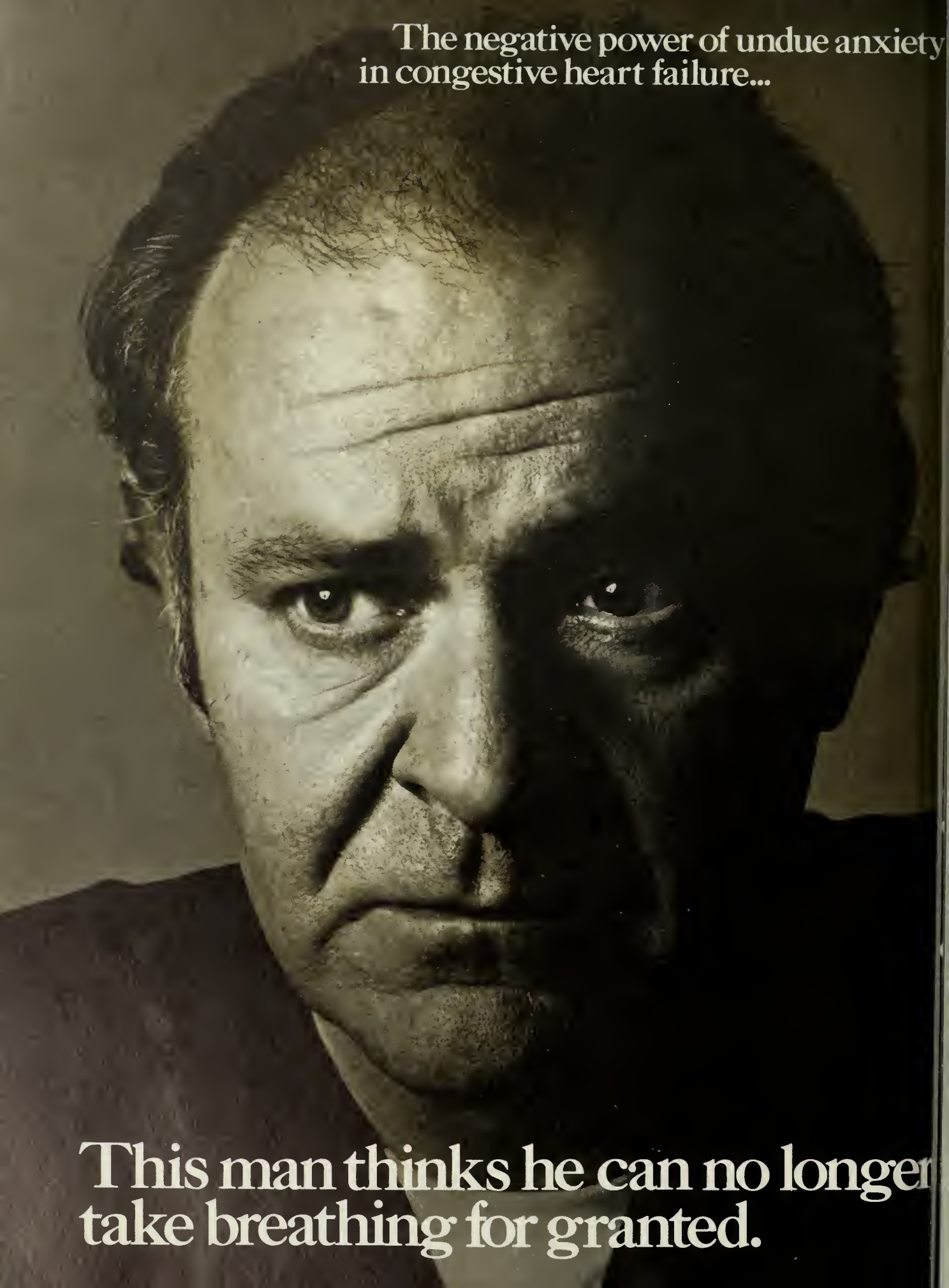
HARVARD medical alumni bulletin

March/April 1972


The negative power of undue anxiety
in congestive heart failure...
This man thinks he can no longer
take breathing for granted.

Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

Aid in rehabilitation

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

Concomitant use with primary agents

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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The tour program covers areas where those who might otherwise prefer to travel independently will find it advantageous to travel with a group. The itineraries have been carefully constructed to combine the freedom of individual travel with the convenience and savings of group travel. There is an avoidance of regimentation and an emphasis on leisure time, while a comprehensive program of sightseeing ensures a visit to all major points of interest. Hotel reservations are made as much as a year and a half in advance to ensure the finest in accommodations.

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30 DAYS $1759

1972 marks the eighth consecutive year of operation for this outstanding tour, which offers the greatest attractions of the Orient at a sensible and realistic pace. Twelve days are devoted to the beauty of **JAPAN**, visiting the ancient "classical" city of **KYOTO**, the modern capital of **TOKYO**, and the lovely **FUJI-HAKONE NATIONAL PARK**, with excursions to ancient **NARA**, the magnificent medieval shrine at **NIKKO**, and the giant Daibutsu at **KAMAKURA**. Visits are also made to **BANGKOK**, with its glittering temples and palaces; the fabled island of **BALI**, considered one of the most beautiful spots on earth; the ancient temples near **JOGJAKARTA** in central Java; the mountain-circled port of **HONG KONG**, with its free port shopping; and the cosmopolitan metropolis of **SINGAPORE**, known as the "cross-roads of the East." Tour dates include outstanding seasonal attractions in Japan, such as the spring cherry blossoms, the beautiful autumn leaves, and some of the greatest annual festivals in the Far East. Total cost is $1759 from California, $1965 from Chicago, and $2034 from New York, with special rates from other cities. Departures in March, April, June, July, September and October 1972.

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22 DAYS $1329

This original itinerary explores in depth the magnificent scenic, cultural and historic attractions of Greece, the Aegean, and Asia Minor—not only the major cities but also the less accessible sites of ancient cities which have figured so prominently in the history of western civilization, complemented by a luxurious cruise to the beautiful islands of the Aegean Sea. Rarely has such an exciting collection of names and places been assembled in a single itinerary—the classical city of **ATHENS**; the Byzantine and Ottoman splendor of **ISTANBUL**; the site of the oracle at **DELPHI**; the sanctuary and stadium at **OLYMPIA**, where the Olympic Games were first begun; the palace of Agamemnon at **MYCENAE**; the ruins of ancient **TROY**; the citadel of **PERGAMUM**; the marble city of **EPHESUS**; the ruins of **SARDIS** in Lydia, where the royal mint of the wealthy Croesus has recently been unearthed; as well as **CORINTH**, **EPIDAUROS**, **IZMIR** (Smyrna) the **BOSPORUS** and **DARDENELLES**. The cruise through the beautiful waters of the Aegean will visit such famous islands as **CRETE** with the Palace of Knossos; **RHODES**, noted for its great Crusader castles; the windmills of picturesque **MYKONOS**; the sacred island of **DELOS**; and the charming islands of **PATMOS** and **HYDRA**. Total cost is $1329 from New York. Departures in April, May, July, August, September and October, 1972.

MOGHUL ADVENTURE

29 DAYS $1725

An unusual opportunity to view the outstanding attractions of India and the splendors of ancient Persia, together with the once-forbidden mountain kingdom of Nepal. Here is truly an exciting adventure: India's ancient mounuments in **DELHI**; the fabled beauty of **KASHMIR** amid the snow-clad Himalayas; the holy city of **BANARAS** on the sacred River Ganges; the exotic temples of **KHAJURAHO**; renowned **AGRA**, with the Taj Mahal and other celebrated monuments of the Moghul period such as the Agra Fort and the fabulous deserted city of Fatehpur Sikri; the walled "pink city" of **JAIPUR**, with an elephant ride at the Amber Fort; the unique and beautiful "lake city" of **UDAIPUR**; a thrilling flight into the Himalayas to **KATHMANDU**, capital of **NEPAL**, where ancient palaces and temples abound in a land still relatively untouched by modern civilization. In **PERSIA** (Iran), the visit will include the great 5th century B.C. capital of Darius and Xerxes at **PERSEPOLIS**; the fabled Persian Renaissance city of **ISFAHAN**, with its palaces, gardens, bazaar and famous tiled mosques; and the modern capital of **TEHERAN**. Outstanding accommodations include hotels that once were palaces of Maharajas. Total cost is $1725 from New York. Departures in January, February, August, October and November 1972.

Rates include Jet Air, Deluxe Hotels, Most Meals, Sightseeing, Transfers, Tips and Taxes. Individual brochures on each tour are available.

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25 SHATTUCK STREET
BOSTON, MASS. 02115

JOSEPH GARLAND '19
Editor Emeritus

GEORGE S. RICHARDSON '46
Editor

JOAN F. RAFTER
Managing Editor

LYN LEVY
Assistant Editor

MILTON C. PAIGE, JR.
Advertising Consultant

MEDIAREP CENTER, INC.
1127 STATLER OFFICE BUILDING
BOSTON, MASS. 02116
(617) 482-5233
Advertising Representative

A SPECIAL ISSUE ON COMMUNITY MEDICINE

CREDITS: Cover by Henry L. Moss '73; Hakim Raquib, pp. 13, 15, 17, 20, 21; Photography, Inc., pp. 22, 23; Courtesy of the Adirondack Museum, p. 29; William Joplin, p. 30; Stephen Arnon '72, pp. 34-36; Fabian Bachrach, p. 42 (Federman); Bruce Reider '75, pp. 46, 48.

OVERVIEW

Mounting Costs Force Tuition Increase

Steadily mounting costs for Faculty and employee salaries, and for the maintenance and operation of the Schools' physical plants have forced the Harvard Medical School and the Harvard School of Dental Medicine to raise tuition by $250, effective with the start of the 1972-73 academic year. The increase will raise tuition from $2500 to $2750 and will bring the Harvard tuition up to the median assessed by the majority of privately endowed medical schools in the nation.

Expressing his sincere regret that the step had become necessary, Dean Robert H. Ebert said, "I fully recognize that this increase will add to the already heavy burden of educational costs that about two-thirds of our student body are now unable to meet in full." He stressed, however, that the rise in tuition would not change the School's long-established policy of disregarding the financial needs of candidates during the admission process.

Perry J. Culver '41, chairman of the financial aid committee, explained:

> Although it has become necessary to raise tuition and fees, the Harvard Medical School and School of Dental Medicine remain committed to the belief that there should be no insurmountable financial barriers to a medical education. Once students are accepted, every effort will be made to assist them in meeting the cost of their education through loans, opportunities for medically related employment, and some scholarships. The amount of available funds for scholarships, however, is insufficient to meet the needs of students.

Dr. Culver emphasized that every effort would be made to keep the student's total loan indebtedness to a reasonable level that will not compromise his career plans.

The flexibility of the loan program has been increased through a recent decision of the University to join the Federal Guaranteed Insured Loan Program which provides an initial subsidy for students of low and moderate income families during college, graduate school, and government services.

Additional features accomplished in the long-term planning by Harvard include proposals for a progressive repayment schedule of loans when they become due, starting out at low repayment levels and increasing as earning power increases.

In addition, under the provisions of the Health Manpower Professional Training Act of 1971, those medical school graduates who choose to practice in physician shortage areas for a minimum of two years, will be entitled to forgiveness of a substantial portion of their loan indebtedness.

Bok Names Peterson 4th Vice President

Chase N. Peterson '52, currently dean of admissions and financial aid of Harvard College has been appointed vice president for development and alumni affairs. When he announced the appointment, President Bok stated, "We are extremely pleased that Dr. Peterson has accepted this new position. In addition to the duties implicit in his title, he will be one of a small group of key people with whom I consult on a wide range of problems."

Dr. Peterson has been chairman of the faculty committee which selects each year's entering class in Harvard College, and is also responsible for the program of scholarships, loans, and part-time work that assists more than half of each class in the College. In addition to his duties at the College, Dr. Peterson has taught medicine on the Harvard service at Cambridge City Hospital, and has contributed to the Cambridgeport Clinic, which provides free medical care for non-student youth.

Prior to joining the Harvard staff, Dr. Peterson was a practicing physician in Salt Lake City, and worked diligently on the Schools and Scholarships Committee of Harvard Alumni. A specialist in internal medicine, he was an assistant clinical professor of medicine at University of Utah School of Medicine, a member of the American Society of Internal Medicine, and a Diplomat of the American Board of Internal Medicine. Dr. Peterson will assume his new duties on July 1.

Report of the Winter Alumni Council Meeting

The Harvard Medical School Alumni Council held its regular winter meeting on January 21 and 22, 1972. Maxwell Finland presided over two days of reports and spirited discussion.

Assistant to the President for Resources and Development, Mr. Harry C. Colt made some comments on the general aspects of fund raising in Harvard University. He stated that in President Bok's administrative plan, there are four vice presidents. Mr. Colt's office, with its supervision of alumni records can serve as a data bank for the alumni office and development office of all of the faculties of the University. As for giving, Mr. Colt said that 1970-71 was a very good year with almost $60 million raised throughout the University. Approximately 40 percent of the 51,000 Harvard College alumni give as compared to 54 per-

cent of the 6,300 alumni of the Harvard Medical School. The development of a Harvard College Fund Council, composed primarily of the chairmen for the class gift of the reuning elasses, has increased the annual giving by Harvard College alumni from $2.5 million to $4.5 million over the past six years. Moreover, 67 pereent of the annual giving for Harvard College eomes from the reuning classes. The Fund Couneil funetions in a coordinate fashion with the Associated Harvard Alumni; each has its own goals and is equally recognized for its particular contribution to Harvard. Although the Fund Council focuses on each class agent, it also utilizes an organization of regional solicitors. The HMS Alumni Council diseussed ways in which its hard-working elass agents eould be properly reorganized into some sort of eomparable body.

Next, the co-chairmen of the Student-Faculty Committee made a rcport of their plans and aetivities. Mr. David Calkins '74, president of the second year class, said that the Student-Faculty Committee was involved in a number of areas. As advisor to the Dean regarding matters of particular concern to students, much attention has been devoted to the evaluation of students' academic performance (see report elsewhere in this issue) and to the functions of the student promotion boards. Student input into the reorganization and redireetion of Promotion Board activity has been accepted by the Administrative Board of the faeulty. The Student-Faeulty Committee has sponsored activities of value to the students, such as participation in an orientation program for the first year class, and has provided support for the Black Health Organization and the Medical Area Womens' Group. Both organizations are eoneerned with recruitment of potential medieal students.

Mr. Kim Masters '72, president of the fourth year class, listed a number of topics which he hoped would be considered this spring by the Student-Faculty Committee. Among those listed were: 1) a reexamination of the role of the offiee of student affairs and the advisory system; 2) review of some areas of the eurriculum which seemed less satisfying to the students; 3) a question of awarding honors and election to AOA when there are no grades given during the first two years of medical sehool; 4) discussion with the university health service about areas which appear to be inadequate sueh as gyneeology, psychotherapy, dental eare, and referral to specialists; 5) development of a continuing program whereby alumni would invite the students to visit them for a few days and observe their practice of medicine.

In eonelusion, Mr. Masters expressed the hope that students and alumni might have a mueh wider opportunity to talk with eaeh other on Alumni Day. To this end, we plan to invite all HMS students to the Alunni Day luneheon and urge them to strike up conversations with the alumni.

Dr. Culver, Miss Beverly Bennett, Mr. Joseph Donnelly, and Dean Ebert eommented briefly on their expericnees and impressions of visits with alumni groups in New Orleans, Houston, Dallas, Denver, Seattle, Portland, San Franciseo, and Los Angeles. In addition, local alumni met with members of the Medieal School Admissions Committee to conduct regional interviews of applicants for the HMS in Chieago, Ann Arbor, Atlanta, and Durham, North Carolina.

Some of the feed-back from the regional gatherings has been presented via an "Open Letter to the Alumni" in the January/February, 1972 issue of the *Alumni Bulletin*. Among other reactions encountered on these trips, two are worthy of emphasis here. First, when invitations were sent to alumni in various eities, there was initial caution on the part of many, that these regional gatherings were just another fund raising attempt. Onee they were assured that we were there to talk about HMS, the atmosphere became perceptibly more felicitous. Hopefully, this knowledge will generate a much larger attendanee at regional alumni meetings next year.

Secondly, among younger alumni who are repaying loans to the Medical School, there appeared to be some resentment about the receipt of the class agent's letter requesting annual giving. One alumnus replied that he had originally felt angry but now that he had finished paying off his loan, he would really like to give to the School. Discussion of this problem by the Alumni Couneil resulted in a decision to have elass agent letters to the younger classes make note of the loan repayment burden but to also eneourage a token gift in order to establish the habit.

There was further discussion and elarification of proposed changes in the by-laws regarding assoeiate membership. The eouncil recommended that the following ehange be presented to the annual meeting of the Harvard Medical School Alumni Assoeiation on June 2, 1972 for a vote: that the following be substituted for Section 4, artiele 3, part B: "All persons who have held a elinical, teaching, or research appointment at a Harvard teaehing hospital or at the Harvard Medieal School for one year or longer as intern, resident, or fellow. Those assoeiate members who, from time to time, have rendered special service to the Harvard Medieal School may be invited by vote of the Alumni Couneil to become members."

Nomination for candidates for election to the Alumni Couneil were discussed and voted (see the nominees elsewhere in this issue). Names presented by the committee to bring in nominations for officers of the HMSAA were discussed and a president-elect and secretary were ehosen. There was also a recommendation that the three immediate past presidents be invited to attend eaeh eouneil meeting as non-voting members.

The program for Alumni Day was discussed in some detail. The council voted to host a dinner for the senior elass on Tuesday, April 25, 1972.

PERRY J. CULVER '41

Austen Appointed Bayles Professor

K. Frank Austen '54, professor of medicine at HMS and physician-in-chief at the Robert B. Brigham Hospital, is the first incumbent of the Theodore Bevier Bayles Professorship (see Jan./Feb. *Bulletin*).

Dr. Austen heads what is considered to be one of the most outstanding clinical, research, and teaching programs in the fields of immunology and rheumatology in the United States. His basic and applied research has been documented in well over 100 original articles and a large number of reviews published since 1955.

From 1959-61 Dr. Austen was a United States Public Health Service postdoctoral research fellow with Dr. John H. Humphrey in the department of immunology in Mill Hill, London, England, and subsequently received a Research Career Development Award from the NIH. The director of the NIH has invited Dr. Austen to deliver the annual Dyer Lecture for 1972. This prestigious lectureship was established in 1950 to honor Dr. Rolla Eugene Dyer upon his retirement as director of the National Institutes of Health.

Dr. Austen

A Fellow of the American College of Physicians and the American Academy of Allergy, Dr. Austen includes among his many professional memberships, the American Society for Pharmacology and Experimental Therapeutics, the American Association of Immunologists, British Society for Immunology, and the Transplantation Society. He is a member of the editorial boards of six professional journals.

Goldberg Named Pfeiffer Professor

Irving H. Goldberg, M.D., Ph.D., has been appointed the Gustavus Adolphus Pfeiffer Professor of Pharmacology, and will also serve the Medical School as head of the department of pharmacology. When announcing the appointment, Dean Robert H. Ebert stressed that this marked the return of pharmacology as a strong and vigorous member of the preclinical sciences. "Under Dr. Goldberg's leadership, clinical pharmacology will become an integral part of the department of pharmacology."

Dr. Goldberg

The reestablishment of a strong department of pharmacology answers a growing demand among students for instruction in the discipline beyond what is now currently offered. Dr. Ebert noted that funds are already in hand to establish three professorships in clinical pharmacology. When the incumbents are named, although they will be based in affiliated teaching hospitals, they will maintain strong ties with the central department in the Quadrangle.

Dr. Goldberg joined the Faculty of Medicine and the staff of Beth Israel Hospital in 1964. An authority on the molecular mechanisms of agents affecting nucleic acid and protein synthesis and function, he served as head of the Endocrine Unit at BIH from 1964-68, and as physician from 1964-72. From 1968-70 he was chairman of the Division of Medical Sciences.

In addition to strengthening the department of pharmacology and broadening its ties with clinical pharmacology in the Medical School, Dr. Goldberg is greatly interested in linking the department more closely with the molecular and physiological sciences. He feels that advances in molecular and cell biology make pharmacology ideally suited as a vehicle for their translation to the therapy of disease states.

Dr. Goldberg received the M.D. degree from Yale in 1953 and the Ph.D. degree from The Rockefeller Foundation in 1960. He is a member of the Association of American Physicians, American Society of Biological Chemists, and the American Society for Clinical Investigation, among others. He has also served as member of the editorial board of *Endocrinology*.

Four Chosen Full Professor

Four new appointments to full professor were recently announced within the Faculty of Medicine. A brief biographical sketch on those appointed follows.

Stanley Baum, M.D., professor of radiology at Massachusetts General Hospital and director of the vascular radiology unit at MGH. A professionally superlative radiologist in angioradiography, Dr. Baum has made important contributions to both the diagnosis and therapy of visceral bleeding. A 1957 graduate of the Faculty of Medicine at the University of Utrecht, he comes to HMS from the University of Pennsylvania School of Medicine where he was professor of radiology. He was also assistant radiologist at Presbyterian-University of Pennsylvania Medical Center.

Franklin H. Epstein, M.D., professor of medicine, head of the Medical School's department of medicine, and director of the Thorndike Memorial Laboratory at Boston City Hospital. A distinguished scientific investigator, teacher, and clinician, he was one of the first to document and elucidate the renal mechanisms of the sodium retention induced by volume shifts. Dr. Epstein's teaching ability is attested to by his being awarded, by vote of the senior class at Yale Medical School, the Francis G. Blake Award for the teaching of medicine. He received his M.D. degree from Yale in 1947 and was made a member of the faculty in 1954. He has been professor of medicine there since 1966.

Paul M. Gallop, Ph.D., professor of biological chemistry at the School of Dental Medicine and biochemist in the department of orthopedic surgery at Children's Hospital Medical Center. An outstanding scientist, Dr. Gallop has made highly original and important contributions in three major areas; collagen structure, collagenase purification and action, and protein sequencing via mass spectometry. He received the Ph.D. degree from Massachusetts Institute of Technology in 1953. Since 1963, he has been professor of biochemistry (biophysics) at Albert Einstein College of Medicine and a Career Investigator at NIH.

Peter Goldman, M.D., professor of clinical pharmacology. A superior clinician and researcher, Dr. Goldman played a major, and in some areas a totally independent, role in one of the most significant developments in biochemistry within the past ten years — the isolation and characterization of acyl carrier protein (ACP). He received the M.D. degree from Johns Hopkins University in 1957. Since 1963 he has been Senior Investigator in the Arthritis and Rheumatism Branch of the National Institute of Arthritis and Metabolic Diseases.

REMINISCENCES

Anyone who has been a part of Harvard Medical School is joined in a common heritage. Much of what is held to be the essence of HMS is illusory, intangible, and difficult to articulate. Yet, much remains vivid and alive, a memory to be shared.

With this issue, the *Bulletin* introduces a new column, Reminiscences, so that such memories may not be lost to time.

Alumni are invited to submit an amusing anecdote, quotation from a lecture or speech, or personal experience relating to their HMS days. It may be as short as a sentence, a paragraph, or 2-300 words. The editors hope that each Reminiscence will be signed, but it will be printed anonymously if the author so desires. As with all contributions, approval of the editorial board is necessary prior to publication.

Dr. Blumgart

In my first-year anatomy course, I was confounded by the strange convolutions and intricacies of the cerebrum. I naively concluded that insight would be afforded me by walking across the street to observe the surgical penetration into this strange region by our professor of surgery, the world-renowned brain surgeon, Dr. Harvey Cushing.

I was met at the entrance to the operating room by Adolph, his massive diener, who covered me with face mask, surgeon's cap, and full surgical regalia, and sat me down in the first row of seats right next to the operating table.

The great moment of entrance arrived. Harvey Cushing assumed his position at the head of the table right next to me. He then looked up and said to me, "Good morning, doctor. What is your name? And tell me, doctor, where do you practice?"

I stammered meekly, "Please sir, I am only a beginning first-year medical student in anatomy."

My tremor, if not my pallor, must have been evident beneath all the surgical paraphernalia for he did not order me evicted as I anticipated, but instead, asked Adolph to bring in a Gray's anatomy.

Then, step by step, he demonstrated to me the anatomic structures as he exposed them, allowing me to follow the anatomical text.

This episode is endlessly repeated throughout Harvard Medical School; the recipient of one generation becoming the donor in the next. It is a genetic trait of every HMS department.

HERRMAN L. BLUMGART '21

Meeting Questions Methods of Evaluating Student Performance

On January 26, 1972, the Student-Faculty Committee sponsored an open meeting to discuss the preclinical Promotion Board and the methods of evaluating student performance in the preclinical years. Before discussing that meeting, I would like to explain why it took place. That is perhaps the most important part of the story.

Early this fall, the Administrative Board (the executive council of the faculty) decided that the time had come to reexamine the role and operation of the preclinical Promotion Board. Specifically, there was a concern about how the Board should deal with such matters as the requirement for a student to do remedial work, or even to withdraw from the Medical School if that should appear necessary. On the one hand, there had been increasing concern (among students particularly) that policies on such matters were much too vague. This had, in the past, led to considerable confusion and anguish, which could perhaps have been avoided were guidelines and procedures spelled out more clearly. On the other hand, there was some sentiment (primarily among faculty serving on the Promotion Board) that the present pass/incomplete grading system needed review. Under the old A,B,C grading system some straight forward formulas had been used to determine the adequacy of a student's performance. The present system did not lend itself quite so well to such quantification, making the job of the Promotion Board a more difficult one. Thus, no one was really satisfied with the present situation, and it was the decision of the Administrative Board to appoint a subcommittee to discuss the problem and submit recommendations.

Soon after this decision had been made, the Student-Faculty Committee met to discuss the matter of student evaluation and the procedures of the Promotion Board. Part of the responsibilities of the Student-Faculty Committee (in addition to serving as an advisory body to the Dean and overseeing the operations of Vanderbilt Hall) are to discuss and make recommendations upon matters of joint concern to students and faculty. Clearly, the Promotion Board was such an issue. Although the Student-Faculty Committee reached few conclusions about policy at the initial meeting, members were unanimous in their feeling on one point — any committee which would make recommendations about student evaluation should have student members. Since minority students had been particularly concerned about several aspects of this problem, it was felt that it might be useful if their participation especially could be sought. It was therefore the decision of the Student-Faculty Committee to recommend the appointment of student members to the existing Administrative Board subcommittee. Such an appointment would not have been completely without precedent, since students were already serving as full members on all major standing committees of the faculty. In addition, there were two student "observers" on the Administrative Board itself.

To make the story brief, such an appointment, however, was never made. The subcommittee did meet once with a representative of the Black Health Organization (a group composed of Black medical students) and twice with members of the Student-Faculty Committee. The fact that students did not have the opportunity to participate in a continuing way with this group was indeed unfortunate. The Student-Faculty Committee believed that additional, ongoing student input would have been useful to the discussions of the subcommittee and communicated its concern about this omission to the faculty. In the end it was decided to hold the open meeting as a means of soliciting additional, needed, student (and faculty) opinion on the matter of student evaluation.

An announcement of the meeting as well as a "working paper" prepared by the Administrative Board subcommittee was sent to all students and faculty members. The meeting began at 7:30 PM and lasted until about 11:00 PM, at which time slightly over half of the seventy-five people originally in attendance were still present. Although many issues were discussed at the meeting, the majority of time was spent discussing grading. This was also the greatest area of interest to those who had addressed written comments to the Student-Faculty Committee prior to the meeting. As might be expected, opinion on this issue was not uniform, although there was a general consensus that the pass/incomplete system should be retained with more detailed information (such as examination scores or other sorts of evaluation) made available to the preclinical Promotion Board. Judging by those in attendance, there was not "wide spread opinion" (a quote from the working paper) that grades should return. This was essentially the conclusion made by the subcommittee. On other issues some modifications were made in the recommendations of the subcommittee. The Appeals Board suggested in the report was originally to be composed partially of members of the Promotion Board. It was the consensus of the open meeting that this should be an entirely separate group and that it should, in addition, have student members. Student members were also suggested for the Advisory Board, a group which is to design remedial programs, as well as a plea made for an improvement of the entire student advisory system. All of these modifications are included in the final report of the Administrative Board which is scheduled to come before the faculty for its approval.

The open meeting met its objective of providing a forum for free discussion among students and fac-

ulty on an important issue of academic policy. Hopefully, this sort of discussion will take place in the future without such formal mechanisms. It is essential to the life and future prosperity of the School.

David Calkins, HMS '74
Co-Chairman, Student-Faculty Committee

Moseley Fellows

Two HMS alumni have been awarded Mosley Traveling Fellowships for 1972-73.

The Fellowships are awarded to those who have demonstrated their ability to make original contributions to knowledge; who have planned a program of study that will contribute significantly to their development as teachers and scholars; and who clearly plan to devote themselves to careers in academic medicine and the medical sciences.

The Fellows are:

Dale Purves '64 was awarded the Fellowship for the second year to carry on with his work with Dr. R. Miledi in the department of biophysics, University College, London. Dr. Purves' work will continue, but on a different track, as he feels it would be of greater value to pursue a new series of experiments. The work that stimulated this plan change was the finding that the activity of denervated muscle seems to have an important influence on controlling its responses to transmitter substances. Dr. Purves and a colleague have set up a small tissue culture laboratory and can now routinely pursue this discovery in new lights. He feels that the experiments are exciting because they raise unanticipated questions about the nerve-muscle relationship and because the results may represent a more general mechanism by which a postsynaptic cell modifies the effect of the innervation it receives.

John E. Heuser '69 will also spend a year in the department of biophysics at University College, London, to advance his knowledge and accelerate his studies of changes in morphology that accompany changes in synaptic function. The studies began during his work as a research associate in the laboratory of neuropathology and neuroanatomical sciences as a commissioned officer in the USPHS. In London, Dr. Heuser plans to learn advanced electrophysiological and biochemical skills that will help him to organize a multidisciplinary study of the nervous system in the future. He will work with Professors Katz and Miledi, in their unique laboratory that offers intensive exploration of synaptic functions, a commitment to the advantageous preparation of frog neuromuscular junction, and a vigorous postdoctoral program. Dr. Heuser feels that this is the next step in a career concerned with the study of the nervous system.

HMS Establishes Unique Radiology Center

A research center, the first of its kind in the nation, is now part of Harvard Medical School's department of radiology. A $1 million grant from the Institute of General Medical Sciences, NIH, has established the Research Center in Diagnostic Radiology.

The director of the Center is Herbert L. Abrams, M.D., Philip H. Cook Professor of Radiology, head of the department of radiology at Harvard, and radiologist-in-chief at the Peter Bent Brigham Hospital.

Associated with Dr. Abrams as co-directors will be: S. James Adelstein '53, associate professor of radiology; Norman K. Hollenberg, M.D., Ph.D., associate professor of radiology; Harry Z. Mellins, M.D., professor of radiology; Sven J. K. Paulin, M.D., professor of radiology, Harvard, and radiologist-in-chief, Beth Israel Hospital; and Juan M. Traveras, M.D., professor of radiology, Harvard, and radiologist-in-chief, Massachusetts General Hospital. As the program develops, the Center will involve the facilities and personnel of the Medical School's teaching hospitals.

The emphasis of the program will be on new advances in understanding the regional circulation of the blood in the heart, kidney, liver, and other organs. Radiologic techniques will be utilized in conjunction with pharmacologic, physiologic, morphologic, physical, and biochemical methods.

The Center will also offer training to investigators and academic radiologists. Students will come from the other Harvard departments and other medical schools in New England. Training programs will be funded by separate NIH grants.

Laboratory research will be conducted primarily in the department facilities at the Shields Warren Radiation Laboratory. Clinical studies will be carried out mainly at the Peter Bent Brigham Hospital. Plans will be developed in later years to include research at the other Harvard teaching hospitals.

Dr. Abrams

The multiple objectives of the Center will result in a program having broad relevance to clinical medicine and should have a significant influence on the diagnosis and treatment of important diseases in man.

PROMOTIONS AND APPOINTMENTS

professor

Stanley Baum: radiology at Massachusetts General Hospital
Franklin H. Epstein: medicine
Paul M. Gallop: biological chemistry in the School of Dental Medicine
Peter Goldman: clinical pharmacology
Arthur J. Linenthal '41: medicine at Beth Israel Hospital
John E. Mack '55: psychiatry at Cambridge Hospital
Ronald A. Malt '55: surgery
Fred S. Rosen: pediatrics
Harry Schwachman: pediatrics at The Children's Hospital

clinical professor

Howard A. Frank: surgery

associate professor

Ernest M. Barsamian: surgery at WRVAH
Mortimer J. Buckley: surgery
H. Franklin Bunn: medicine
Paolo Caldini: anesthesia at Peter Bent Brigham Hospital
Roberta F. Colman: biological chemistry
Robert E. Dinsmore: radiology at MGH
Donald J. Glotzer: surgery at BIH
Stephen E. Goldfinger: medicine at MGH
George B. C. Harris: radiology at TCH
Ronald D. Hunt: comparative pathology at New England Regional Primate Research Center
Ralphael H. Levey '59: surgery
Farahe Maloof: medicine at MGH
Eldred D. Mundth '59: surgery
Paul F. J. New: radiology at MGH
James C. Orr: biological chemistry
Majie S. Potsaid: radiology at MGH
Chester B. Rosoff '46: surgery at BIH
Peter H. Schur '58: medicine
John J. Skillman: surgery
Peter E. Sifneos '46: psychiatry at BIH

associate clinical professor

Nina S. Braunwald: surgery
Robert G. Ojemann: surgery

assistant professor

Ronald J. Anderson: medicine at Robert Breck Brigham Hospital
Clyde H. Beck, Jr.: medicine at MGH
A. Richard Christlieb: medicine at New England Deaconess Hospital
W. Hallowell Churchill, Jr.: medicine
Robert J. Corry: surgery
Donald R. Dibona: anatomy in the department of medicine
Michael H. M. Dykes: anesthesia at BIH
Alexandre P. Fabiato: medicine
Joseph T. Ferrucci: radiology at MGH
Josef E. Fischer '61: surgery
Ronald A. Gabel: anesthesia at PBBH
Robert M. Glickman '64: medicine
John M. Head '50: surgery
Stephen E. Hedberg '55: surgery
Dorothy H. Henneman: medicine
Thomas L. Kemper: neuropathology at MGH
Gerald M. Kolodny: radiology
Susan E. Leeman: physiology
Robert L. Morse '58: medicine at WRVAH
Richard C. Pfister: radiology at MGH
Thomas D. Pollard '68: anatomy
David S. Rosenthal: medicine at PBBH
Goran K. Svensson: radiation therapy at Boston Hospital for Women
Bryan P. Toole: medicine
Jan Vaage: radiation therapy
Manjeri A. Venkatachalam: pathology
Clarence E. Zimmerman II '61: surgery at BIH

assistant clinical professor

Constantine L. Hampers: medicine

principal associate

Horacio H. Barahona: microbiology and molecular genetics (virology)
John B. Das: surgery
Norval W. King, Jr.: comparative pathology (electron microscopic histology)

principal research associate

Charlotte F. Litt: preventive and social medicine (microbiology)
Robert C. Thompson: biological chemistry

lecturer

Jeb Boswell: medicine

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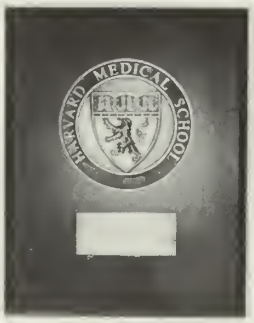

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editorials

Provocative, or Merely Provoking?

The correspondence in response to Dr. Lium's article in the November-December *Bulletin* indicates, as one would hope, that whatever their division over costs and fees, our Alumni are concerned about quality. In this issue we print a rebuttal to Dr. Lium which, fortunately for its readability, is not entirely free of rhetoric. After all, moral indignation and the rhetoric which goes with it make for exciting journalism, and the *Bulletin* is ready to plead guilty, if necessary, of such journalism from time to time.

Our correspondents have pointed out that money-grubbers will be money-grubbers, however regulated. Salaries do not make caring physicians, and as Dr. Marks notes in his letter (page 38) hospital-based physicians may be status seekers (having professionally-oriented goals) rather than caring physicians (having consumer-oriented goals). In this issue of the *Bulletin* we see that spokesmen of the radical left, claiming to represent the community of consumers, are already calling the bluff, as they see it, of such "liberal," "academic," hospital-based physicians (see Howard Levy's article, page 20).

Dr. Rubenstein's rhetorical question, "where is the incentive for excellence?" has been given an amusing answer by general practitioner William D. Poe in a superb editorial in the *New England Journal of Medicine*, January 13, 1972. He asks what incentive will make a physician care for a patient who is not only impecunious but chronically ill, incurable, perhaps malorodous — and has an uninteresting disease! His answer is a shiny new status for the doctor: a new specialty to be called "marantology."

With this issue alarmed readers may fear that the *Bulletin* is about to become "The Magazine of Radical Chic." Be assured that we are what we always have been, ever ready to reflect the interests of our Alumni. We prefer provocation to sedation, and rather fancy ourselves as a magazine of true adventure.

Symbiotic Relationship

This issue of the *Bulletin* is devoted to ghetto and community medicine. Singly, and as a group, the articles demonstrate not only the active concern of many young physicians with the everyday pressing health needs of the poor in American cities, but also their determination to find new organizational means to attack such problems.

Reading these papers inevitably poses questions about what role universities and their medical schools should properly assume in responding to the needs of the community. Two extremes are possible — neither of which would be espoused by anyone. On the one hand, were medical schools to concentrate exclusively on serving the primary health needs of the poor who happened to live in their immediate community, they would perforce neglect the opportunity to advance basic medical knowledge and practice. In the long run even their limited patient clientele would suffer. On the other hand, were they to concentrate solely on the development of basic knowledge in fields that happened to be of interest to their researchers, and to train physicians just to care for (and care about) "interesting" medical problems as seen in the specialty beds of large medical centers, they would soon become socially irrelevant.

Somewhere in between these polarities our teaching institutions are seeking a course where their special capabilities, resources, and needs can effectively mesh and interact with the broader needs and institutions of society. To the extent that such a course is successfully plotted, the community should benefit at the same time that the teaching and research programs of the university will stand to gain fresh purpose and direction. This demands an ability to devise mutually useful working relationships among the university, the providers of health care, and the representatives of the people to be served.

Harvard today, both in the clinical area and in health services research, is witnessing many such efforts. A great number of its physicians and its scholars from other disciplines are joining with public policymakers and health program administrators to seek new ways to improve the manner in which people receive their health services, and to control runaway health service costs.

The Harvard Community Health Plan, for example, is a pioneer among university-sponsored health maintenance organizations. The Medical School and its teaching hospitals have established staff, research, and teaching affiliations with a number of Boston neighborhood health centers. The Harvard Center for Community Health and Medical Care has the mission to study and evaluate both traditional and innovative ways of organizing, financing, and delivering health services, and to prepare young health professionals to assume responsible leadership in a future that seems certain to produce major institutional change. In other parts of the university too — at the Kennedy School of Government, in the Department of Economics in the Faculty of Arts and Sciences, and at the Business School — faculty and students are joined in their concern about questions of health administration, economics, and management.

For its part, the Harvard Center for Community Health and Medical

Care considers its own working associations with staff and administrators in more than 30 different health agencies and programs to be essential in the fulfillment of its mission. It would indeed become a sterile exercise for the staff and fellows of the Center to conduct health services research remote from the firing line in hospitals, neighborhood health centers, health maintenance organizations, nursing homes, schools and clinics — or remote from governmental and voluntary agencies that may be directing their policies.

At a time when, in response to widely acknowledged failures of the "health system," prescriptions for change run a dime a dozen, the yawning gap between the ease of propounding ideal solutions and the difficulties of putting them into practice is becoming ever more painfully apparent. Many of these difficulties stem from an as yet primitive level of knowledge about the way health services are currently provided, used, and paid for by aggregations of people, and about the ways these people perceive their needs for medical care. Others stem from a similarly imperfect understanding of how institutions function, and how they evolve in response to pressures for change. It is in such areas that the capabilities of universities can be helpful to those responsible for planning, financing, or administering health services.

For example, health maintenance organizations may indeed prove to be the solution to many problems, as their congressional proponents claim. And more extensive use of allied health workers may indeed permit a more efficient use of physicians' time. But how can an H.M.O. or any other organization make sensible staffing decisions without knowledge of how physicians in different specialties, practicing in different types of ambulatory care settings, currently allocate their time among various types of direct services to patients, paperwork, telephone calls, committee work, research, teaching, and their own continuing education? Or how can H.M.O. premium rates be established without knowledge of the number of visits likely to be made by populations of differing age, sex, and educational characteristics? Only within the past few years has health services research begun to produce readings on these central questions, through such empirical studies as the Harvard Center for Community Health and Medical Care has been conducting with the staff of the Bunker Hill Health Center, and as Harvard's Family Health Care Program research team has been conducting among practicing physicians.

As another example, state regulation of hospital expansion may be desirable to avoid costly facility duplications, and to encourage new program planning better tailored to populations' health needs. But as yet, the administrator has only piecemeal information by which to assess those needs. Nor do legislators yet have a sound base of information and theory that can enable them to identify a regulatory structure which will in fact accomplish their desired purpose.

Quite apart from innovation of new forms or practices, those who set policy and those who direct both new and established institutions need continually to know how well their program is meeting the needs of the patients they set out to serve, the physicians who staff them, and the students and teachers in their training programs. To be able to correct past miscalculations and to adjust to ever changing conditions, they must be able to monitor performance, assess costs in relation to benefits across all aspects of the operation, and compare these costs and benefits with those in similar programs. Those who direct ambulatory care centers — outpatient departments, mental health clinics, neighborhood health centers, etc., almost universally lack such feedback information. The Center for Community Health and Medical Care is currently developing and disseminating a data collection and analysis system to permit the generation of such information. Six university-sponsored comprehensive care plans are working with the Center towards this end, as are three neighborhood health centers in Boston. National applications seem likely.

Moving beyond research linked to specific health program needs, findings from the wide range of both theoretical and empirical studies in health currently being pursued at Harvard should, of course, ultimately devolve to the direct benefit of the community. For example, critical review of the conceptual problems surrounding the application of benefit cost analysis in the health field should improve the use of this analytic tool by people in national, state and local governments as they seek to reach decisions on allocating funds among alternative choices of programs. The results of analysis of the impact of the various alternative tax programs now proposed to support national health insurance yields information of particular significance to the poor, upon whom the burden of regressive taxation falls heaviest.

Too often successful innovations in health care services, such as those described in this *Bulletin,* fail to become incorporated into the ongoing institutions of society and perish at the end of research-dem-

onstration funding. Until more becomes known about the fundamental nature of societal and organizational change and the forces that shape it, this wasteful process will no doubt continue. One study in which the Center is collaborating probes this question by examining the effect of previously conducted programs in coronary care in five New England states on the distribution of resources, the process of regionalization, and the outcome of services provided in coronary care units. Another study examines recent experiences of various Blue Cross plans, medical foundations, and other organizations that have made deliberate attempts to modify incentive structures, thought to be influencing hospitals and physicians, in the hope of stimulating their greater interest and activity in containing hospital costs. Other studies at the Center examine the impact of different structural arrangements on the provision of care, as for example, different patterns of hospital utilization by comparable populations entitled to different types of insurance benefits.

In summary, to the extent that they receive encouragement to do so, the men and women who are out in the "community" — be it national, state, or local — developing the kinds of innovative changes in health services touched on here and illustrated in succeeding pages of the *Bulletin,* as well as those who are trying to reorient or reorganize established health agencies or institutions, are actively looking for help on a broad range of questions. They look to the university to fulfill its traditional function of disseminating and developing new knowledge to shape more effective policies and programs to meet the needs of the people they serve. In return, to the extent that the university is able to respond credibly and creditably, its teachers and students can learn at first hand the kinds of problems whose amelioration or solution demands rigorous research and analysis now and in the immediate future. Teaching programs, too, are enhanced by direct observation of the myriad constraints that impede most efforts at institutional change.

PAUL M. DENSEN
Director
Center for Community Health
and Medical Care

Is Community Medicine Up a Tree?

ALEX:
You've missed that point completely, Julia:
There *were* no tigers. *That* was the point.

JULIA:
Then what were you doing, up in the tree:
You and the Maharaja?

The Cocktail Party by T. S. Eliot

The worlds of the medical school and hospital traditionally seek systematization and order. The political world, on the other hand, is uncertain and shifting. Heretofore, by mutual consent, the two worlds have developed separate orbits. This tradition, and the unchallenged assumptions of separatism, are being eroded in many ways. Nowhere has the interface been as deeply affected as in the so-called "community medicine."

Enormous strides have been made in environmental sanitation and in the control of communicable diseases. As these advances have been made it has become commonplace to comment on the changing nature of illness. Yet the health problems of today that relate to poverty have always been inseparably associated with America's poor: namely, malnutrition, prematurity, stunted and twisted mental health, drug addiction, alcoholism, crime, and the continuing manifestations of those communicable diseases that are still inadequately contained among the poor. The chronic diseases of degenerative, metabolic, neoplastic, and congenital nature have been brought into relatively recent prominence by an aging population and the control of infectious disease. Chronic diseases, as well as the man made diseases of a highly developed nation, involve the entire population. The coexistence of the diseases of the nineteenth century with those of the twentieth is confusing and confounding. Nevertheless, the practice of medicine has always been determined by the prevalence of particular disorders, the state of scientific insight, and social attitudes towards health and disease, but very little by political attitudes, inasmuch as they relate to the *care of the individual.* In this context, the role of the physician remains unchanged; to prevent and diagnose disease; to cure and assist the patient.

It is presumptuous to contend that a medical school or hospital can contribute to the fundamental political reforms needed to eliminate poverty and the illnesses associated with being poor. Medical care cannot root out the causes of poverty. The basic solutions are political, not medical. In fact, some "models" of community medical care may actually retard community development and reform by masking the effects of social neglect. Further, health planners tend to forget that the overriding long-term interests of the disenfranchised demand an equal measure of self-determination. The widespread attempts to develop "area plans" relating certain institutional providers of health care to people living in defined areas ignores the right of individuals to decide where they shall obtain care (never challenged in middle or upper class areas). The oft cited benefit of establishing an institutional relationship with a single community, ignores the high mobility of people in general, and low-income urban residents in particular. Much of the recent effort seems, if not consciously so designed, at least in practice, to appease simmering political fury by the meager redistribution of resources.

While each medical school and

hospital attempts to develop its community medicine vehicle, the orientation of medical education remains effective in producing an increasing number of physicians who will not practice medicine amongst *any segment of the population.* That the practice of the physical care of the patient becomes increasingly unpopular among young doctors, at the same time that the drums beat loudly for the so-called "community medicine" leads one to further doubts about the validity of the movement at present. Perhaps the point is that there is no real community medicine. Rather, community medicine is the useless phrase of a society that is groping for a true sense of community. The factors of ethnology, residence, income, occupation, education, and age used frequently to define members of communities may invidiously distract and separate us from the search for the commonality of man.

When we speak portentuously of community medicine we reveal not that we have discovered a new type of medicine, but that we have rediscovered some of our fellow men. A remarkable aspect of the current craze for community medicine is its popularity in academic circles, where it is viewed not only as offsetting harassment from the "Community" but also as a new career opportunity. The opportunity for students to develop a sense of pride in clinical competence is limited by the interest of their mentors in the care of the whole man. In medical schools, the lack of moral and demonstrable support for the concept that it is a privilege and challenge to practice medicine in *any community* renders the "community medicine" movement suspect.

LAVINIA:

I must say it.
I know . . . of a doctor who I think
  could help you.

EDWARD:

If I go to a doctor, I shall make my
  own choice;
Not take one whom you choose. How
  do I know
That you wouldn't see him first,
  and tell him about me
From your point of view? But I
  don't need a doctor.
I am simply in hell. Where there
  are no doctors.
At least, not in a professional
  capacity.

LAVINIA:

One can be practical, even in hell:
And you know I am much more
  practical than you are.

EDWARD:

I ought to know by now what you
  consider practical.

The Cocktail Party by T. S. Eliot

The poet, not surprisingly, is closer to the mark than most of us.

ROBERT B. BERG '52

Michael G. Michaelson, a member of the Medical Committee for Human Rights, has done graduate work in sociology at the University of Pennsylvania, where he is a fourth year student in the School of Medicine. His writing has appeared in *The American Scholar, The Saturday Review, The New England Journal of Medicine, The New York Review of Books, The Nation, Ramparts, Health Rights News, The New York Times Book Review,* and other journals. He is currently at work on a book, *Healing: Notes on Medicine and Revolution,* which will be published by Harcourt Brace Jovanovich.

The Radical Perspective

EARLY last month I received from George S. Richardson, editor of the *Harvard Medical Alumni Bulletin,* an invitation "to write a brief, editorialized feature that might serve as something of a springboard for our special issue." This issue would be devoted, he wrote, "to ghetto and community medicine." Certainly I was pleased to be asked, but I was also, I must confess, confused and somewhat hesitant. In his letter Dr. Richardson referred to a long essay of mine, "The Coming Medical War" (*The New York Review of Books,* July 1, 1971), in which I had suggested that American medicine was rapidly becoming divided into three hostile, even warring, camps: the politically conservative American Medical Association, dwindling in power, which represents generally the interests of the traditional fee-for-service entrepreneur; the academic, generally "liberal," hospital- and medical school-based practitioners, who comprise an ambitious medical elite in this country which threatens to become a new "medical priesthood;" and a third group, the people's health movement, which is loosely composed of consumers, health workers (including radical professionals), women's groups, community people and students — composed, that is to say, of anyone with an interest in American health care, regardless of their "credentials." It is with this radical health movement that I strongly identify; in my article I tried my best to explain why.

Hence my confusion, my hesitation: How could someone unalter-

ably opposed to the idea of a medical elite contribute, in good conscience, to a journal which is, after all, published by and for members of that elite? For Harvard medical alumni! The elite of the elite! ("Harvard," the full page advertisement says. "Nice to have around." No false modesty there.) Then I noticed that Howard Levy, who as an army physician had gone to prison for acting upon his intense moral commitment to end the war in Vietnam, and who has been active in radical medical politics since his release, was scheduled to contribute to the issue. My interest aroused, I called the editorial office for details, asked to see the "copy" which would make up the issue I was to introduce. Joan F. Rafter, the *Bulletin*'s managing editor, was kind enough to comply, and to include some back issues, too, so that I might familiarize myself with your journal.

My eyes were opened. On the one hand, to be sure, my worst suspicions were confirmed. The parochialism, the narrowness of vision were evident enough. ("Difficult as it may be to believe, Building D is closed," read the lead-in to one cover story.) Evident, too, was the almost pathological involution which seems all too characteristic of alumni publications. (As nice as it must be for Professor Curran, for example, does it really *matter* that he is the only member of some HEW commission "to represent both a law school and a medical school faculty?") At the end of one editorial titled "Century of Progress" (September / October), the author admitted quite openly to "blowing Harvard's horn." In those words he captured the essence of the magazine, I thought, with not inconsiderable élan.

Closer inspection, however, revealed something more. Once I mustered the courage to get past the cover of the November / December number, which portrayed, as readers may recall, a rather forbidding sign ("CLOSED: NO ADMITTANCE"), I found not only a spirited exchange on the war in Vietnam between a member of the class of '32 and a member of the class of '71, but a very nearly militant (although disappointingly liberal) attack on fee-for-service medicine by one Rolf Lium '33. My nose twitched instinctively, and I went back to September / October. Sure enough, a sensitive piece on emergency medical care in East Pakistan was to be found there — albeit sandwiched between Libritabs and Valium, Class Notes and Charter Flights, The First National Bank of Boston ("When the time comes to hang out your shingle. . . .") and, of course, Harvard's blowing horn. Genuine issues, genuine *feelings*, seemed undeniably to be slinking into these staid pages.

I turned to the xeroxed typescripts of this issue's contents, therefore, with what had by now become genuine interest, even (dare I say it?) enthusiasm. Enthusiasm which proved justified. The medical war, I rapidly discovered, is indeed coming to Harvard, as readers of this lively issue will attest. (Lively? Perhaps *dangerous* is better: in the crossfire of heated argument and rebuttal one reflexly hits the metaphorical dirt.) I should like to offer just a few brief comments.

FIRST, as Howard Levy makes clear (and as I have myself tried to point out in various essays and reviews), the radical perspective on contemporary American medical politics is very different from — indeed diametrically opposed to — the liberal perspective (which is, we think, essentially elitist, authoritarian, manipulative, bureaucratic and anti-democratic). In the essay reprinted here Howard does an excellent job of outlining that distinction, but such a necessarily abbreviated account cannot really do justice to the richly complex radical analysis, and I would urge interested readers to consult *The American Health Empire* (Random House, 1971), *Health Rights News* (published monthly by the Medical Committee for Human Rights, 710 South Marshfield, Chicago, Illinois), and the Health-PAC *Bulletin* (17 Murray Street, New York City) for additional documentation and details. That done, I think, the health movement's reference to "medical school empires" and the like will make a great deal more sense to readers who may be unfamiliar with such language; and our rhetoric, which is by no means empty, will be a great deal less alienating.

For alienation must, at all cost, be avoided. It is not only patients who are oppressed by the current medical malaise in this country, but doctors as well. Some of the agonized, ill-tempered replies to Rolf Lium's article make this frightfully, but instructively, evident. And they make another thing apparent as well: my own capacity for arrogance, my own willingness to assume that some people are worth less than others. A "radical" elite would be as noxious as a medical elite, as smug as Harvard. (In fact, "radical elite" is oxymoronic, just as "medical elite" ought to be.) These letters, although I disagree strongly with what most of them say, helped me realize that I had almost been guilty of precisely what I was trying to reject: a tendency to see people in one dimension rather than in all. I wondered last week if I would have hesitated in writing for, say, the Black Panther newspaper, and my answer was No. Those of us fighting elitism must guard against simply being elitists in reverse; for the most part, I can proudly report, the health movement has been acutely conscious of this danger and has worked to avoid it.

A second point concerns Dr. Lium's attack on fee-for-service in the last issue, and all the rebuttals printed in this one. Those of us in the health movement believe strongly that charging money for medical care is not merely inefficient or unscrupulous: it is obscene. But I found myself sympathizing less with Lium than with some of his critics, specifically on the matter of the impersonality, regimentation, bureaucracy and distorted priorities of institutionalized medical care, whether the institution be a "progressive" uni-

versity hospital or a government-funded satellite clinic. Ira Marks' letter is especially good on this subject, and it illustrates (along with one or two of the others) what seems to be the natural alliance between radicals and those conservatives who share a genuine respect for the relationship between doctor and patient as well as a healthy distaste for the academic medical elite's Orwellian plans.

There is indeed a dilemma facing "busy practitioners who, although they may disagree vehemently with the AMA, are hardly represented by academic medicine" — a dilemma which will be exacerbated if present trends are not modified radically. Dr. Marks and his colleagues will bear witness to the fact that specialists and bureaucrats are taking over; diabetologists and thyroidologists are replacing endocrinologists; hypertension experts compete with nephrologists to decide who will manage a diastolic pressure of 130 and in the process make their patients nearly nervous enough to offset whatever good alpha-methyldopa might have done; "community medicine" specialists are claiming to be the experts who know how to allocate the experts. Where will it all end? On this point medical history is clear enough. As the medical elite becomes smaller and smaller, those outside of it become defined as incompetent, as quacks.

Is there an alternative? There is indeed; but the old order cannot be restored; a new one must be built. For concerned physicians I can only offer this advice: Visit a truly *free* clinic, one which has grown out of the community rather than been imposed upon it, one in which health workers and community people work as colleagues; attend a meeting of your local chapter of the Medical Committee for Human Rights, talk to the people there instead of forming opinions from a distance, ask questions; share your knowledge and skills and experience and problems; join us now.

A third, final, comment. The crisis we are observing today in the structural, institutional, and economic spheres of contemporary medicine will, I feel quite certain, soon extend very much deeper, to touch upon the very *concept* of a physician. Doctors will be faced by a sophisticated public which demands not only free medical care and free medicine, but *free access* to medicines and to medical tools. Patients will demand to know *in technical detail* about their bodies, about disease mechanisms, about therapeutics. They will demand the knowledge and ability to evaluate not only what doctors charge but what they do. They will demand, in fact, to treat themselves, their families and friends, whenever feasible. What we are witnessing today may prove to be the very small tip of a very large chunk of ice. The "march," as Howard Levy calls it, may be not so much "through institutions" as through ideas. It will be a formidable march indeed, but one well worth making. And, if we can make it together, confront and argue with and even embrace one another on the way, it may even be fun.

MICHAEL G. MICHAELSON

A Contest for HMAB Readers

Mr. Michaelson says that "alienation must, at all costs, be avoided." Despite this protestation, his viewpoint is, of course, deeply alien to that of the majority of our alumni, and his rhetoric, certain to bring about more polarization than persuasion, is likely to be counter-productive. His hesitation in appearing among us, is, accordingly, matched by that of your editor in accepting his contribution.

The medical profession has a right to resist the "impersonality, regimentation, bureaucracy, and distorted priorities" of socialized medicine. Mr. Michaelson (and Dr. Levy) believe that patients are also entitled to resist as effectively as they can, the "impersonality, regimentation, bureaucracy, and distorted priorities of institutionalized medical care," whether it is in a university hospital or a government-funded clinic. These doctors and patients are asking for a new order, whether they realize it or not.

The *Bulletin* asks HMS alumni not to tilt at the windmills of Michaelson and Levy, but to tell us how you feel the problems raised by these young men should be solved. Please give us a full and considered response — not legalistic and not overdocumented. The best written will be published promptly and in full.

The Challenge of the Neighborhood Health Center

DURING the last decade, a large number of Neighborhood Health Centers (NHC) have developed throughout the country. To illustrate the magnitude of this proliferation, in the Boston area alone there are presently 29 such centers. The impetus for forming the NHC's has been, in general, the inadequacy of existing medical care delivery systems in meeting the needs primarily of the urban poor. The political force that catalyzed the formation of the NHC's has varied. In some cases, a community group has been the prime mover, in others, a city health department, in still others, a university teaching hospital. In the vast majority of cases, categorically provided federal funds have enabled the centers to begin service, supplemented by, with the passage of time, third party reimbursement. If the last decade can be termed the "proliferation phase" of NHC history, it is likely that the years to come will represent the "consolidation phase." In the near future we are likely to see, partially as a result of federal pressures through the "Health Maintenance Organization," "Family Health Center" and similar programs, the amalgamation of small NHC units with the objective of improving services, providing a fuller service package, and realizing necessary economies of scale.

The activities of the NHC have some elements in common with large multispecialty group practices, especially those operating under prepayment financing. The NHC's are, however, unique in significant respects. Their uniqueness stems in large part from two considerations: they address themselves mainly to poverty populations for whom economic and environmental factors frequently play primary etiologic roles in medical illness; they often focus on a geographically defined population, thus making possible a wider range of activities using schools and community organizations more than one generally considers in a group practice setting.

Presently, NHC staffing is drawn largely from university hospital-based medical specialty training programs. As physician and medical director of the Mary Elizabeth Mahoney Family Life Center in Boston, I have had the opportunity to observe for two years, some of the dominant themes of NHC practice to which the vast majority of existing training programs are poorly matched. It is the purpose of this essay to develop several of these themes.

The Medical Content of Practice

Keith Hodgkin,[1] in his perceptive analysis of primary medical care, has graphically pointed out the divergent medical content of hospital and ambulatory practice. The young physician beginning ambulatory practice finds himself dealing with a set of problems around which he has limited training and experience. Thus, for example, venereal disease and asymptomatic bacteriuria are the infectious diseases with which he deals repeatedly, not bacterial pneumonia and septicemia as in his training days. The plethora of psychologic illness in ambulatory practice, estimated to motivate between 20 and 40 percent of visits, is an area for which the hospital trained physician is poorly equipped. In his training, he has had little formal exposure to psychopharmacology, the use of supportive psychotherapy and group techniques, family therapy and the like.

In addition to the mismatched content between ambulatory practice and hospital-based training, the style of approach to the patient and his problems also differs in the two settings. Whereas in the hospital, the urgency of the disease state, in concert with a system of hierarchical peer scrutiny that judges harshly errors of omission often results in a "do and measure everything" approach, a more systematic stepwise style is generally more effective in the ambulatory setting. This transition of tempo is particularly difficult for some physicians, and is made all the more difficult because of an absence of this kind of exposure during training.

One frequently hears diatribes these days about the variability in quality and performance of physicians in the ambulatory setting. Perhaps this is explained in part at least, by the fact that the "ambulatory-care" fund of knowledge of practicing doctors is largely gathered through self education, often haphazardly acquired, rather than through the formally considered curricula or close apprenticeship monitoring given his "hospital-care" knowledge. As an example of this, consider on the one hand the amount of time, effort, and money expended on the annual physical examination in contrast to the paucity of information available on what should be included in this activity and how the package should vary with age, sex, occupation, etc. In the context of finite resources in which the NHC physician operates, is a lipoprotein electrophoresis or five minutes careful instruction about the consequences of cigarette smoking likely

[1] Keith Hodgkin. *Toward Earlier Diagnosis;* E. & S. Livingston Ltd. Edinburgh & London, 1966.

by Matthew A. Budd '60

to be more cost beneficial to the patient? This type of issue is rarely if ever dealt with in the hospital-based training program.

The Neighborhood Health Center Physician as Decision Maker

In the course of his hospital-based training, the physician rarely finds himself in the role of program developer. His role is generally one of responding to the problems raised by his diseased patients; his choices lie within the limits of his technical knowledge and understanding. Rarely, are financial constraints major factors in his decision making in the university hospital training program.

In contrast, in the NHC setting, the physician frequently finds himself in the role of decision and policy maker in a new delivery vehicle. In addition, his decisions must be made with respect to two major constraints: a fixed patient population and a fixed dollar budget. Moreover, much of his time will be spent in the care of well persons. For this group, the range of possible services is much broader than for the ill, and includes health education, disease detection, disease prevention, and the like. The tools needed to elaborate the elements involved in these decisions include not only the technical-medical, but also economic, epidemiologic, and sociologic considerations. These disciplines are nonexistent in the curricula of hospital-based training programs.

The constellation of parties involved in the decision making process is also unique to the NHC. Whereas hospital-based decisions are generally made by the physician alone, hopefully in concert with the patient, NHC decisions are arrived at with the additional input of center management and consumer representation. The center management is generally concerned with the economic implications of policy formation. The consumer group brings an expression of community needs, priorities, and values to the process. Since the NHC physician usually is a product of a social background different from that of his patients, the input of the consumer group is invaluable in emphasizing local human needs. Consider, for example, the complex question of whether or not the NHC should offer family planning assistance to adolescent girls without requiring parental consent. In formulating NHC policy, recognizing that each patient's case must be considered individually, the center management might enunciate legal constraints, the physician the medical issues, and the consumer group local attitudes and customs.

This broadening of input into decision-making processes is not without its dangers. Generally these have to do with role confusion, for example, center management voicing judgment on technical medical issues. This hazard does not, however, detract from the overall value of the process.

The Neighborhood Health Center Physician as a Team Member

The hospital-based physician generally practices in a team of physicians. Except in special situations, such as intensive care units, nurses and other health professionals have traditionally functioned in a subordinate role with little individual judgment and initiative allowed.

In the NHC, on the other hand, the general rule is the delivery of care through a multi-discipline team structure. NHC teams usually include physicians, clinic nurses, nurse practitioners, community health workers, and social workers. Other categories of health professionals such as nutritionists and mental health workers may also be included. The *raison d'etre* of the team structure is the integration of various disciplines in the implementation of a patient care plan. There are other advantages that accrue from the team structure.

Tasks traditionally performed by the physician may be delegated to other members of the team. This implies careful documentation of the task, formal training, and supervision. Thus pediatric nurse practitioners may perform a large portion of well child care, and community health workers may collect detailed patient social histories or be heavily involved in patient teaching. The net result of the delegation of these and similar tasks is more efficient utilization of physician time, and often more attention to non-disease related aspects of health care.

An additional advantage of the team structure derives from the fact that non-physician members of the team frequently share common ethnic and socio-economic backgrounds with the patients. Thus the non-physician health professionals are able to bring to the team a heightened consciousness of patient problems.

For the hospital-trained physician, the transition from the primacy of his role on the ward to team member in the NHC setting is often made with difficulty. The techniques of effective function in a team structure, including the delegation of tasks through carefully designed protocols, a respect for and understanding of the insights of other team members, and the sharing of responsibility for patient care are not easily learned and hopefully, should be experienced during the training period.

In summary, NHC practice places demands on the physician as practitioner, decision maker, and team member, for which he has been poorly prepared during his years of hospital-based specialty training. The lessons learned from, and requirements for, NHC practice should be considered as post-graduate training programs evolve to include new experiences and disciplines.

The Doctor and Social Change

by Howard Levy, M.D.
Health-PAC

In any discussion of medical care delivery to low income communities, it is not surprising that hundreds of proposals are offered, accompanied by as many basic philosophies. Perhaps the only common strain running through these discussions is the belief that services are desperately needed.

In order to meet this need, groups ranging from government to the individual communities themselves have constructed various programs for the delivery of health care. Neighborhood health centers, satellite public health clinics, free clinics, and so forth, have engendered debates on many-sided issues. Topics such as consumer-provider relations have been argued back and forth by all concerned. Words like "professional elites," "community control," "advisory boards," "governing boards," "representativeness," and "responsiveness" have entered the vocabularies of people in the health system. Though the words have been used by all involved, their definitions differ considerably depending upon the user's basic philosophy of health care delivery.

Dr. Howard Levy draws many of these words into play, but his basic feelings about health care are "radical" rather than liberal. Dr. Levy is on the staff of Health-PAC (Policy Advisory Center), an independent, nongovernment, research and education center committed to the radical restructuring of the American health system. The Center offers a variety of workshops for medical, nursing, health science, planning, and law students; gives technical advice to community groups; and publishes a monthly bulletin. In the following article, excerpted from *Social Policy Magazine* (March/April, 1971), Dr. Levy provides us with his interpretation of the differences between the liberal and radical health movement.

In the early 1960's the Kennedy "New Frontier" spirit began to draw the medical community into the "war against poverty." It did not take medical school empires long to realize that they could reap a bonanza from OEO to operate health facilities in poor communities. And, of course, the government assumed that medical schools, given the money, could be expected to deliver competent medical care to poor people. Medical schools had the expertise and manpower to "do the job right."

Initially overlooked was the fact that patient care has never been a priority of medical schools. While departments of community medicine suddenly sprang up or expanded in order to reap the federal harvest, the priorities of the medical teaching centers remained what they had always been — profits, research, and teaching. It should have been clear from the start that those priorities, in addition to the strict professional hierarchy that exists at medical teaching centers, would overwhelm progressive health professionals with even the best of intentions. It could have been predicted that the interests of the professionals, not those of the people, would be served when medical schools, chasing after the federal dollar, boldly stepped into poor communities, medicine bag in hand.

The rhetorical keynote of the HEW-OEO programs was "community participation." The reality, however, was professional control. While the AMA ranted about government interference in the practice of medicine, the more liberally inclined physicians within the academic medical community adopted the "mod style" of the 1960's. In comparison with the stodgy AMA, the liberals who spoke of health care as "a right, not a privilege" sounded pretty hip. Nevertheless, both the "progressive" academicians and the AMA had one thing in common — a deep-rooted fear of popular control of antipoverty health programs.

We believe that consumers of health care have the right to make socio-political decisions regarding the health care they receive. We also believe that the community has the right to scrutinize, judge, evaluate, and, if necessary, challenge the doctors' technical expertise.

But some are mortified by this

prospect. They undoubtedly envision community people having nothing better to do than nit-pick over every decision the doctor has made. What is far more likely to happen is that technical decisions will be challenged from a much broader perspective. There is reason to believe that the medical profession might be enriched rather than hampered by such criticisms. We have, for example, already witnessed women's groups challenge the right of doctors to dispense birth control pills promiscuously. Prior to this challenge, many doctors had prescribed "the pill" without having taken its potentially serious side effects into account. Had a challenge from women's liberation groups been launched a decade ago, some lives would no doubt have been saved.

. . . We agree [with liberals that say] the ends sometimes justify the means; our difference has to do with who decides the ends. Unlike [most liberals], we lean toward the conclusion that it is the oppressed who have the right to make that decision. It is women, not the doctors, who should decide on abortions; it is junkies who should decide to use or not use methadone; it is draftees who should decide to use or not to use a medical deferment in Vietnam . . . The difference between [liberals] and ourselves is profound. It is the difference between professional elitist and democratic decision making. We believe that [under democratic decision making] people may make occasional mistakes, but there is little reason to suppose that these mistakes will be more horrendous than the irresponsibility of those who now wield control over the health delivery system. At the very least, people can be expected to care primarily about receiving decent medical care for themselves and their communities.

At the moment, those in control of the American health system do not have this as their goal; rather, their goals are research and teaching. They are dedicated to increasing institutional profits and individual salaries; ever-larger research

efforts that bear only a tenuous relationship to real medical needs; and the control of medical education in order to reproduce doctors in their own image.

It may be true that preventive health programs and community medicine programs have carved out their own niche, which yields hundreds of millions of dollars in federal grants each year. But this still does not approach the research grantsmanship of the more technically oriented medical researchers and departments. For example, the decision of medical schools and teaching hospitals to invest large amounts of time in teaching students and doctors-in-training about extremely rare diseases, such as maple syrup urine disease (better known as branched chain ketonuria), while at the same time all but ignoring diseases of epidemic proportions, such as alcoholism, surely cannot be understood in apolitical terms. Rather, it reflects the medical institutions' political priorities.

In an ideal setting, with no restrictions on resources, a society could choose to opt for every conceivable medical service. But in the real world, this state of bliss does not exist. It is not a neutral and apolitical decision to opt for cardiac transplants, renal dialysis, and hyperbaric oxygen chambers, though these highly sophisticated life-saving procedures are certainly in and of themselves valuable. In a society whose economy is undergirded by the creation of artificial scarcities, these elaborately expensive techniques compete for funding with other options that may save many more lives, such as child-care centers and treatment programs for narcotic and alcohol addicts.

It is clear that what is needed is a total reordering of the purposes and priorities of preexisting medical institutions — hence, the ultimate demand for community/worker control of these institutions. In the meantime, community activists have opted for alternatives (such as free clinics, Welfare Rights diet clinics, etc.) that, though inadequate in an ultimate sense, provide some medical service where none previously existed. Moreover, in most of the examples cited, community activists have recognized the shortcomings of the alternatives and struggle daily to confront the real enemy — the powerful men who have robbed the community of the medical facilities that by every moral standard legitimately belong to the people.

We, and all community groups of which we are aware, look forward to the day when the control of major medical institutions passes over to the men and women who work in and utilize the services rendered by those institutions. When that day comes, makeshift alternatives will be abandoned. But we recognize that this will involve a protracted march through these institutions.

Community Medicine: Separate but Equal?

by Randolph B. Reinhold, M.D.

Dr. Reinhold is Director, RDMG, instructor in surgery, Harvard Surgical Service at Boston City Hospital, and Director of Community Medicine at New England Deaconess Hospital.

MOST persons who have examined the urban health care scene in America have come to the same conclusion: medicine reflects the basic segregation entwined in the fabric of our society. Nowhere is the relationship between race and affluence more evident than in the style and mechanism for health care delivery in inner city America. The majority of America's leading medical institutions and hospitals are located in the inner city, and are to be both congratulated and condemned for their role in the development of this apartheid system. The modern teaching hospital has delivered health care to the urban poor when few other physicians could or would choose to do so. In every American city, there is ample evidence of the private practitioner's retreat to the suburbs, and the abdication of the role of the individual physician to the large hospital-based clinic.

Since the time of the Flexner report, the basic American medical education scheme has required patient populations for the training of young physicians. The teaching hospital's need for a ward-service population and the inability of the poor to find other medical services, led to the natural union of these two during the middle third of the 20th century. While the overall quality of medical care delivered was equal to that in many other communities, anger developed in the poor communities over the manner in which the care was delivered. Large waiting rooms were not conducive to individual care. The frequent change of physicians left the patient *in vacuo* and without an identifiable doctor. To the poor, the doctor-patient relationship was transient at best and frequently missing. The doctor became a large impersonal institution, yet within the same institution personalized private care was being delivered to the affluent. The lack of uniform access to beds or physicians rapidly became identified with the financial and racial structure of the patient population. Even more poignant was the fact that few of the knowledgeable medical and allied health professionals in a given institution ever used the clinic system for their own medical care. So long as the administrator, nurse, and others chose a highly trained, private physician for their care, but relegated the poor to the clinic, there could be little question the clinic offered second-class care. It was all the more aggravating that physicians, at the conclusion of their residency, almost uniformly moved to more affluent quarters and a more affluent clientele, establishing private practices to deliver the quality care they had learned, in some cases, at the expense of the poor.

In the past decade, awareness of the deficiency of the health care delivery system has generated interest in community medicine. Unfortunately in many instances, the name was different but the system remained unchanged. Hospitals, realizing that patients would no longer tolerate the clinic system, developed neighborhood health centers to meet the growing need for personalized attention and maintain a stable patient population. While the emphasis and spectrum of services at the neighborhood health center were different, all too frequently basic health care remained discontinuous. Few of the community physicians actually cared for their patients when admitted to the back-up teaching hospital. Physicians capable of managing hypertension in the community are not the physicians in charge when the patient develops a major complication such as a myocardial infarction. The patient is frequently left in limbo, for, during a major illness when rapport and the doctor-patient relationship are most needed, he is transferred to institutional care and a different set of doctors. Many, if not most, of the health centers are actually triage centers for the classic hospital-based ward-medical system, a la Flexner. Many are really mechanisms to get the runny noses out of the emergency room. In this framework, the Roxbury Dental and Medical Group, Inc. began in the fall of 1969.

Naively, the original physicians of the Roxbury Dental and Medical Group felt it would be a simple matter to open a private doctor's office in the community of Roxbury. Per-

ceiving that the need for quality private medical care was great, we tried to operate the office at a minimum fee schedule with practice concepts similar to group practice in affluent communities. The original financial backing for the renovation of the clinic had come from an outside corporation in New York, generating an air of carpet-bagging, a label all too readily pinned upon the group. The initial response was minimal and in many respects antagonistic, as community leaders boycotted efforts to develop patient acceptance. The community was justly apprehensive that another group of White physicians had entered the Black community without consulting them or making a real effort to include them in the decision-making process.

RDMG was fortunate, however, in establishing a liaison with a few concerned patients who, while appreciative of the services delivered, were adamant that community control become a reality.

ESSENTIAL to the incorporation of the Roxbury Dental and Medical Group, Inc. with its community and consumer directed Board of Trustees, was a recognition of the social interactions involved when community Blacks assumed a role of leadership over White physicians. The ability of the Board, physicians, and staff of RDMG to recognize and deal with the intrinsic racist programming of individual Americans of all colors, represents the basic framework of this unique medical experiment. The subtle negative programming by our society, which separates people of different colors and background, in large part explains many of the previous failures of social agencies in the urban American cities in the past decade.

Through the catalyzing effect of Racial Confrontation Workshops, directed by the Atlantic Training Associates*, RDMG individually, and as a group, began to face the feelings they had toward themselves and others, both Black and White. As the White physicians moved from their reality of aloof moralism and superiority feelings, the Black leaders moved from their reality of underlying rage and fear. Simultaneously, Black and White moved toward mutual trust and understanding. This understanding allows each member of RDMG to face and express the determinants at work when White male authority figures relate to Black staff members, nurses, and patients; and when Black men and women, raised and programmed in a social climate of fear and inferiority, assume leadership roles in the White elitist profession of medicine.

The establishment of the corporation was the major step forward in community acceptance, for it was

now a reality that the success of RDMG, as well as its ongoing responsibility and benefits, lay in the hands of the consumer and not solely in the hands of the health professionals. Similarly, the Corporation's Board recognized its limitations, and while retaining its decision-making powers, established and maintained lines of communication with physicians and other employees, and learned the problems of health care delivery in their own community. Consumer control in our setting has proved to be a distinct advantage and the most stable base for long-term growth. There is little question that patients will take an ever increasing leadership role in the overall planning of health care needs in every community.

The professional staff was structured as a group practice of medicine, surgery, pediatrics, podiatry, and dentistry offering a broad spectrum of services by fully trained physicians as opposed to residents. Most importantly, continuity of care was maintained from home to office to hospital by the same physician and the patient developed an on-going doctor-patient relationship that had been impossible at large clinics.

If continuity of care was one of RDMG's strengths, comprehensiveness in terms of allied health professionals was a weakness. RDMG has remained independent of federal financing, attempting to test the thesis that private interests can develop more efficient mechanisms to satisfy the same needs. Many similar efforts funded by the government have expended hundreds of thousands of dollars studying the same problems RDMG has experienced during its slow beginnings. Remaining unemcumbered by the restrictions of federal grants has allowed RDMG to seek imaginative answers to these problems more readily.

Existing structures for community health services, e.g. the Visiting Nurse Association, have been operational for decades. We have chosen to develop a closer working relationship with such experienced organizations rather than begin expensive reduplication within our own structure. Our independence has allowed us to join with Dartmouth Medical School in the training of the first ex-corpsman medex in the City of Boston. Given the structure of medical finances in both the inner and outer cities, more efficient utilization of physician manpower, through the use of physician

* ATA is a branch of Pacific Training Associates developed by Drs. Price Cobbs and William Grier, authors of *Black Rage* and *The Jesus Bag*. These psychiatrists have developed and trained leaders to deal with issues of race and its effect on human relations, and have been instrumental in assisting people of various backgrounds and attitudes towards mutual understanding.

assistants and coordination of paramedical units, must be developed by all involved in the health care delivery crisis. While freedom of mobility has allowed RDMG to institute new health services with a minimum of red tape, its private, nonfunded aspects were the source of its financial difficulties during its beginning.

It would be an understatement to say that the financial status of the Roxbury Dental and Medical Group was chaotic, inadequate, and disastrous during its first two years of operation. Initial affiliation with the New York health corporation proved to be an impediment to community relations as well as a financial catastrophe that was saved only by the formation of the community owned corporation. It is of interest to note that the New York corporation has subsequently declared bankruptcy.

MANY physicians begin their practice relying solely upon the fee-for-service mechanism. One of the basic principles of RDMG was to see if a similar process could be developed for the poor, particularly in light of existing third party payments such as Medicaid and Medicare. Pre-payment, while a long-range goal, was impractical for a small private organization. Over 70 percent of our patients are covered under these programs, and it was hoped that they would be sufficient to sustain group practice in the urban poor community.

In actual fact, however, the structure of the welfare and the Medicare payment system only serves to perpetuate the existing patterns and virtually eliminates the chances of success for a fledgling organization like RDMG.

It was especially exasperating to all of our physicians, most of whom were on the supervisory staffs of many of the leading clinics in the Boston area, to find that as experienced Board certified specialists, income for services at RDMG was 40 percent of the fee generated by the residents they were training at the nearby hospitals. Not only was the fee low, relative to the area and services being delivered, but the administrative paperwork and overhead made the functioning of a small doctor's office impossible. Without the administrative, personnel, and financial assistance of the New England Deaconess Hospital, survival would have been impossible during this start-up period.

At present, the Boston Department of Public Welfare pays in excess of $16 per visit to the average hospital based clinic, yet the Department requires special documentation, copies of medical records, and frequently personal appeal before it will pay $12, its limit, to a private, certified specialist. As there is no mechanism to reimburse a quality physician for quality care, the welfare system tends to discourage such practices for the poor. One must be forced to speculate about the present union of the clinic-welfare rates, ward services, and teaching institutions — a self fulfilling prophesy that consumes over 80 percent of the Medicaid monies in the city of Boston. Is the clinic system as efficient as smaller physician practices? Why do the health professionals seldom use the ward services? Will not the teaching of medicine have to be reorganized if we are ever to change the delivery system?

Parenthetically, Medicare itself tends to promote higher medical charges for the poor. The elderly near poor frequently have no insurer and cannot pay the initial $50 deductible, and the 20 percent on remaining yearly charges. Thus the $50 (20 percent) allowance generates only $8 (13 percent) for a primary care charge of $60 per year. Doubling the charge for the same services improves the income to $56 (nearly 50 percent) with increment for every subsequent bill. Multiplied by thousands this differential becomes critical to practitioners serving the inner city.

The health care industry is not unlike the transportation industry, which moves masses of people but whose momentum is often too great to respond to the needs of the consumer. Indeed, like the SST, much of medical instrumentation and construction includes a protocol of irrelevance for the average person. RDMG has tried to strike a delicate balance of personal responsiveness and yet a stability that only size can bring.

Central to the issues facing the medical profession today is the question of individual flexibility versus organizational and governmental control. Honest attempts to avoid duplication are leading to a controlling superstructure that may prevent new ideas from becoming a reality. The basic principles of American economics will always favor making a big institution bigger and yet size is inversely proportional to individual responsiveness. The record and expense of governmental agencies in initiating and maintaining health services, *vis a vis* Model Cities and Boston City Hospital, has not been an enviable one to date. Present criticism over the high cost and low efficiency and effectiveness of the Model Cities units threatens their essential funding. Ironically the establishment of rigid guidelines for comprehensive health care at the outset is a large factor in the vast expenditures. Perhaps the most dangerous concept growing from the present government programs is that of specific geographic catchment areas for utilization of each medical center. To offer free care to an individual at a given center because of his residence, while payment is required if the patient chooses an alternate, is in direct conflict with the free choice of physician. Carried to its logical and planned projection, this concept faces the impossible and undesirable task of developing separate but equal medical facilities for members of the same community.

The Roxbury Dental and Medical Group was founded on concepts of individual choice and responsibility, consumer direction, and universal access. Hopefully RDMG can remain a small but stable voice in the clamor of local and federal bureaucracy.

HARVARD MEDICAL SCHOOL ANNOUNCES

The William O. Moseley, Jr. Travelling Fellowships

THE BEQUEST OF JULIA M. MOSELEY MAKES AVAILABLE FELLOWSHIP FUNDS FOR GRADUATES OF THE HARVARD MEDICAL SCHOOL FOR POSTDOCTORAL STUDY IN EUROPE.

The Committee on Fellowships in the Medical School has voted that the amounts awarded for stipend and travelling expenses will be determined by the specific needs of the individual.

In considering candidates for the Moseley Travelling Fellowships, the Committee will give preference to those Harvard Medical School graduates who have—

1. **Already demonstrated their ability to make original contributions to knowledge.**
2. **Planned a program of study which in the Committee's opinion will contribute significantly to their development as teachers and scholars.**
3. **Clearly plan to devote themselves to careers in academic medicine and the medical sciences.**

Individuals who have already attained Faculty rank at Harvard or elsewhere will not ordinarily be considered eligible for these awards.

There is no specific due date for the receipt of applications or for the beginning date of Awards except that the Committee requests that applications not be submitted more than 18 months in advance of the requested beginning date. The Committee will meet once a year in January to review all applications on file. Applicants will be notified of the decision of the Committee by January 31. The Committee may request candidates to present themselves for personal interviews.

Application forms may be obtained from, and completed applications should be returned to:

Secretary, Committee on Fellowships in the Medical School
Harvard Medical School
25 Shattuck Street, Boston, Massachusetts 02115

Choice, Fees, and Quality

A Critique

by Joel J. Rubenstein '64

As discussions are initiated into alternative modes of medical practice, we need clarity of thought in the analysis of our existing problems and their solutions. Unfortunately, the article "Choice, Fees, and Quality," represents an example of "fuzzy thinking." The following critique attempts to highlight inconsistencies and lack of completeness in Lium's argument. In addition, we shall demonstrate lack of objectivity as the author attempts reasoned argument despite an apparent emotional bias. Whatever the merits or demerits of the Lium article, the issues underlying improvements in health care delivery are of critical importance. Those issues demand thorough and reasoned examination.

Lium proposes in the initial paragraph to re-examine the practice of medicine in the same tradition that led to "regulation of public utilities, antitrust laws, etc." However, he proposes the nationalization of American medicine in contrast to his own citation of American tradition where controls are most often exercised by regulation not nationalization. He then goes on to attack two of the three so-called "property rights" of physicians (his own construct). He deems the first right "free choice of physicians" an absurdity based upon the O.P.D. Clinic of a metropolitan hospital. By analogy to our economic system he must deny the concept of free choice in the purchase of automobiles because some persons are unable to afford a car. Rather the important question should be is "free choice" in fact valued by those who can pay for it, and very importantly what proportion of our population cannot afford it?

He states that the concept of fee-for-service is "incompatible" with preventive medicine. Since preventive medicine and matters concerning the public health frequently involve issues of public policy and instruments of control over large populations, a governmental role has long been recognized. These public agencies, frequently in concert with private or public practitioners have had a major responsibility in areas of preventive medicine. Much of the private practice of pediatricians and obstetricians is in fact preventive medicine. In addition, the Public Health Service, in cooperation with practitioners, has dispensed vaccines and advised in their use in many successful programs, (e.g. DPT, polio, measles, influenza). Thus, while public agencies are major instruments in the area of preventive medicine, I see no "incompatibility" with the concept of fee-for-service.

While many have argued that preventive medicine has been inadequate among our disadvantaged population this as likely relates to the associated problems in nutrition, education, housing, and poor peoples relationship to public agencies.

We agree that many categories of disease are best handled with regionalization. Lium cites no evidence for his contention that fee-for-service is an obstacle to regionalization. The opposition to regionalization lies in many areas including consumer desire for local facilities and existing power bases unrelated to the mode of economic remuneration (fee-for-service or salary).

Lium catalogs instances of over-utilization of services said to be the outstanding flaw of fee-for-service system. In each case he fails to prove the relation of fee-for-service and over-utilization. Two examples are over-hospitalization and excess surgery. However, when comparing the length of stay at V.A. hospitals with length of stay at comparable private non-profit hospitals, we find the patient stays longer at the V.A. hospitals.* In instances where procedures performed by the private physician take place in the hospital when they could as well take place in the office we ought to look to the patients insurance plan for the explanation; does it pay for the same procedure if done in the hospital but not if performed in the office? This bias to the hospital as the locus of delivery of medical care ought not to be confused with the fee-for-service system. Furthermore, we suggest that any study of the utilization of health facilities is incomplete without data on the level of health in the population under study. To indict New England as Lium does for over-utilization of tonsillectomies or hysterectomies without data on the incidence of endometrial carcinoma and beta-hemolytic streptococcal infection is gratuitous. Lium notes that mastectomies are carried out three times as frequently in New England as compared to Sweden, but he fails to indicate the relative frequency in the use of radiotherapy. In addition, he fails to mention that cholecystectomies and appendectomies are carried out almost twice as often in Sweden as in New England.[2]

The discussion of the Codman case is of historic interest, but Lium fails to note the outcome of the issue, peer review. Though he implies without evidence that peer review

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* Average length of stay, federal short term general hospitals 18.3 days.[1]

Average length of stay, Non-federal short term general hospitals 8.2 days.

does not exist outside the Massachusetts General, there is in fact nationwide re-examination discussion, and action from within the profession with a view towards strengthening peer review.[3]

Lium then begins a discussion of government and medicine by citing the "conformist, brainwashed, conservative," primarily self-centered physicians who he earlier noted to be manipulative, and less than ethical. He cites no evidence for these sweeping indictments. It is not surprising that reasoned logic does not proceed from this oversimplified and biased view of the physician.

He then cites exemplary Swedish vital statistics to prove that government medicine is the system of choice. He fails to note that the Swedish statistics were attained when fee-for-service was a major form of physician remuneration in Sweden (prior to January 1, 1970).[4] He also fails to mention the vital statistics of West Germany, Poland, Scotland, Italy, Mexico, USSR, Greece and many others where government medicine prevails but where vital statistics are inferior to our own.[5,6] The vital statistics of a country are determined by the general standard of living as reflected in the level of nutrition, per capita income, quality of housing, and the general level of education and sanitation. If one could control for these elements, would the method of physician remuneration be at all related?

He goes on to cite excellent results in the therapy of carcinoma of the cervix in a centralized unit in Sweden. While this may be true, there are few data regarding the optimal size of such a unit and he does not discuss the limitations of such a centralized unit with regard to the continuing process of alternative modes of therapy out of which the best techniques arise. The latter so-called federal concept has been useful in many social and scientific developments in this country.

Perhaps the most disturbing aspect of the article in his outline of the physicians "Bill of Rights" granted in return for the loss of property rights. It is of interest that while the property rights bear some relationship to patient care, his view of the bill of rights seems to leave the patient out, dealing solely with physician benefits. Does this again reflect his projection of the physician as solely pecuniary? Perhaps the most disturbing aspect is the possibility that one individual or a board of individuals should determine out of their own value system, a lifestyle for another group of individuals who until then had been free to choose their own. Perhaps it is the chilling sense of grayness, sameness, and mediocrity that one senses in his list. Where is the spark, where is the independence, ingenuity, individuality, passion, ambition, and intellect? Where is the incentive for excellence?

We feel that underlying Lium's many indictments of current medical practice lies his philosophy that "any arrangement where fee-for-service can benefit a teacher or physician is subject to manipulation or corruption." This seems a blanket indictment of capitalist system rather than a particular failing of the medical profession. Lium continues "why should anyone believe that physicians as a group are better prepared ethically or morally than teachers, druggists, plumbers, or politicians to handle such a privilege as fee-for-service without abusing it?" We might ask, why should anyone believe physicians are less moral than teachers, druggists, plumbers, etc. Is Lium suggesting that we nationalize all these industries, or is he saying that doctors are more corrupt than others and only the medical industry needs nationalization?

In proposing major alterations in the structure of the health care industry, there must be clear focus upon the existing problems and their origin. One is then in the position to analyze new proposals as solutions to specific problems. Simplistic discussion compounded by emotional rancor fails to inform and, as noted by a current reviewer of health care literature, more frequently such articles are "provoking without being provocative."[7] In the course of the present critique we have cited several diverse problems. Among others these include medical manpower, socioeconomic considerations, delivery systems, and the spiraling cost of medical care. Perhaps costs are the most pressing problem. Medical costs involve physician compensation and productivity, but they also involve drugs and hospital costs. The latter are a product of many factors including the attainment of parity on the part of paramedical personnel, changing medical technology, and the utilization of hospital plant and equipment. In unison these problems have resulted in a state of unrest, anger, frustration, and occasionally panic in the medical consumer, supplier, and in our government. Too frequently the response is an unreasoned single sweeping solution. The Lium article singles out his concept of physicians' property rights and proposes to solve our health care problems by eliminating those property rights. In dealing with only one of the many problems in American medicine and implying a solution to all, he must fail. In addition, there seems a clear failure to recognize any possible problems associated with the elimination of property rights upon health care delivery, medical manpower, and individual freedom both for the physician and for society.

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Freud and the Porcupine

by George E. Gifford, Jr., M.D.

In 1909, before he left Europe to present a series of lectures on psychoanalysis at Clark University in Worcester, Sigmund Freud explained the *real* purpose of his trip. He was going to America to catch sight of a wild porcupine, *and* to lecture. Sandor Ferenczi and Carl Gustav Jung accompanied Freud and they spent the voyage analyzing each other's dreams. While in New York, the three visited the Metropolitan Museum, dined at Oscar Hammerstein's Roof Garden, and saw their first movie, complete with wild chasing scenes. Following the lectures in Worcester, Freud and his colleagues were invited to visit the Adirondack camp of Dr. James Jackson Putnam, professor of neurology at HMS.

It seems most appropriate that Freud and his followers should visit Putnam Camp because psychological questions had been discussed there for a quarter of a century. The Camp was formed in the mid-1870's by four Boston physicians: Henry P. Bowditch, the great psychologist; James Jackson Putnam; his brother, Charles,P., a philanthropist and one of American's first pediatricians; and William James, the giant psychologist. Drawn together by their intellects, friendship, and family ties, they chose a spot surrounded by magnificent landscape to discuss the "workings of the human mind and heart."

The Camp was in Keene Valley, New York, at the foot of Giant Mountain. A tract of hardwood forest extended up the mountainside, and a brook rushed through the towering trees to form two pools; one upper, where men could bathe in the limpid ice-cold water, and a lower, more hidden one, perfect for the women.

From accounts written by Elizabeth Putnam McIver in *Early Days at Putnam Camp,* it is not hard to picture the site, resplendent in its simplicity and rustic surroundings. Log cabins were fashioned out of the native materials, and set among the trees. The "Stoop" served as a parlor and library, and two sides of the cabin could be pushed out to provide the occupants with a glorious view of the landscape. The decor was rounded out by a kerosene stove, dwarfed by a huge fireplace and chimney, with large wooden beams crossed above it. Miss Annie Putnam burned a quotation from Horace into the beams, which translated, read: "This corner of the earth smiles to me above all others." Another portion of the Stoop was designed to serve as a stage, and a piano or organ always graced that section of the room.

A dining room was added to another small cabin called the Farmhouse. Long and low, it was equipped with narrow tables placed end to end so that they formed a square. The central attraction in this room was a full suit of armor, created out of relics from a rubbish heap in a nearby pasture. The architect of this conglomeration was Dr. Edward Emerson, the son of Ralph Waldo. Mrs. McIver notes that the room was dubbed a "baronial hall" and it housed "Sir Guy Witherington Fitz-Bowditch Shantum, Sixth Baron Shantum, Fourth Viscount Putney's" battle regalia, complete with a shield, crossbow, and claymire. This chunk of whimsy has been housed in the dining room, or "baronial hall" of Putnam Camp ever since.

The meals at Putnam Camp were of the sort one dreams of. At 7:30 in the morning, coffee and hot milk were brought into the dining room. The mugs were huge, made of gay French china. Fresh bread, a loaf of graham and one of white, were set out with a dish of butter and a honey

comb. The residents helped themselves as they pleased, seated by the stove or outdoors in the sunshine. But, this was only the first breakfast. A second meal followed at 11:30, and the group was brought together by the sound of an iron triangle hanging outside the kitchen door. The meal began with hot cereal, fresh cream, and maple sugar, made from the Camp's own sugar bush. "Dejeuner a la forchette" (or Forky Breakfast) went on to include regular luncheon fare. Mrs. McIver writes that no one was prompt to the second breakfast, and the last to arrive at the table was greeted by a silly little song. We can presume that if Dr. Freud was late to Forky Breakfast, he would have had considerable difficulty translating the following into German:

Little popsy-wopsy, chick a biddy chum
He shall have a pysie-wysie and a sugar plum
He shall yidey-pidey in a coachy woachy too
All around the parky warky
With a cockle doodle doo.

At 7:00 in the evening, dinner was served. Everyone was fresh from a long afternoon climb in the mountains, or a jaunt to the brook. Oftentimes the residents of the Camp would outfit themselves in peasant costume from one country or another. Coffee was served first, followed by a meal as delicious as breakfast. Evenings were spent talking and singing, or telling stories. Each person was noted for a particular story, and was frequently asked to recite it to the group.

It was into this heady setting that Freud, Jung, and Ferenczi came. The Log Book, kept regularly by the residents at Putnam Camp, for September 16, 1909, reads:

> Dr. James Putnam arrived from Boston — Louisa Richardson and Miss Annie Putnam and three foreign doctors came over from Lake Placid (on the 15th) . . .

The entry on September 17th notes:

> Harold Bowditch, Alfred Lowell, James, Jr., and Carl took Herr Jung up Haystack. It was a pleasant walk and on the way back from the Lakes, Alfred and Harold led off at a tremendous pace which Herr Jung called 'record mania thoroughly American.' "

At the end of this entry is a little song, written in Hungarian, followed by a translation. In the margin is written: "Ferenczi — Budapest."

Rare (are) oats, rare (is) wheat and scarce is barley
Rare is the little girl who is pretty
See my maiden how charming she is
Tiny tiny not too tall
Hey little girl — tell this to your mother
If you were a wee bit taller
I would kiss you right away.

No mention is made of Freud, who wrote his reactions in a letter to his family:

> Putnam's Camp,
> September 16, '09
>
> Dear Ones,
>
> It was four weeks ago today that I set out. This will probably be the last letter that arrives before I do. Of all the things that I have experienced in America, this is by far the most amazing. Imagine a camp in a forest wilderness situated something like the mountain pasture on the Loser [the Loser is a mountain near Alt Aussee in the Austrian Alps where Freud and his family spent many a summer]. Stones, moss, groups of trees, uneven ground, which on three sides, runs into thickly wooded hills. On this land, a group of roughly hewn log cabins, each one, as we discover, with a name. One of them is called the Stoop and is the parlor where there is a library, a piano, writing desks, and card tables. Another, the "Hall of Knights" with amusing old objects, has a fire place in the center and benches along the walls, like a peasant dining room; the others are living quarters. Ours with only three rooms is called Chatterbox. Everything is left very rough and primitive but it comes off. Mixing bowls serve as wash bowls, china mugs for glasses, etc., but naturally nothing is lacking and is supplied in one form or another. We have discovered that there [are] special books on camping in which instruction is given about all this primitive equipment.
>
> Our reception at half past two consisted of an invitation to take a walk up the nearest mountain where we had an opportunity of being acquainted with the utter wilderness of such an American landscape. We took trails and came down slopes which even my horns and hoofs were not equal. [Freud's friends said jokingly that his excursions through

The Chatterbox

The Stoop

wild forests were impossible, except with antlers.]

Fortunately it is raining today. There are many squirrels and porcupines in these woods, the latter are invisible so far. Even black bears are seen in the winter.

We had supper in the company of the ladies. One of the hostesses, a lady from Leipzig, is extremely affected. The unmarried sister of Dr. Putnam, a well-preserved lady of middle age, accompanied on the piano a young girl who sang English songs, and then Jung who sang German songs.

The Putnam family understands German, has often been to Germany and also Vienna. Ferenczi and I were taught an amusing board game by two young girls. [Kroconol] Amazing! This morning I sorely missed a barber for all I can do is comb my hair. Fortunately there is the greatest informality in dress, or at least so it seems. Breakfast was very original and plentiful. In short, there will be much to tell you about. We shall start on the last lap of our journey, the day after tomorrow, going to New York, perhaps on the Hudson River. We expect to arrive in New York on the evening of the 18th. My love to you all. Only 14 days more!

Pa

But meanwhile Freud was still searching for his porcupine. In the letter he wrote on September 16, he noted that porcupines were "invisible so far." He was to find his animal shortly thereafter.

Joseph T. Wearn '17 wrote:

> Mrs. Wearn was assigned to take Freud on a mild climb and he appeared with climbing shoes and a staff. They started the climb up a rather gentle hill and had not gone very far before they were greeted by the smell of carion. As they proceeded the stench grew steadily stronger, so much so that Mrs. Wearn suggested that they turn and go downwind. Freud refused so they continued and at last came upon a bloated porcupine, long dead. Freud approached it, cautiously stuck his staff into it, then turned and announced, 'it's dead.'

Another visitor to the camp during Freud's visit, Miss Mary Lee, a cousin of Dr. Putnam, remembers the incident well. Miss Lee, 18-years old then, was given the responsibility of showing the visitors around the area. Though now 80, Miss Lee recalled she had wanted to show Freud, Jung, and Ferenczi the maple sugar camp. Dressed in a stiff straw hat, and carrying a gold headed cane, Freud and company climbed a steep ridge, stumbling upon the porcupine. She remembers that a discussion of the animal's classification followed. She laughingly added that "he was not at all interested in the sugar camp." Miss Lee mentioned Freud's commenting upon the dress of American women, which was, at that time, bloomers and sailor blouses. Freud didn't seem to think that American women did much to make themselves attractive. All in all, Miss Lee felt that Jung, who spoke much better English, was "much more like folks."

In the search for facts about Freud's porcupine, I wrote to his daughter and received this reply:

Nov. 12, 1971

Dear Dr. Gifford:

Thank you for your letter of November 8th. I cannot remember a "story" about the porcupine, but I can tell you about the porcupine itself.

It seems my father saw a porcupine for the first time when he was in Putnam Camps, and that he was very impressed by it. Therefore, as a parting present, he was given a porcupine, made I believe of bronze or some other nice metal, which he proudly brought home with him. It is several inches big, has very impressive [quilts] striking out and has since then stood on his desk, where it still is. Curious-

ly enough, when you pass your hands over it, the quills they give out a nice musical sound.

Whether there is any link between this porcupine and the Schopenhauer story of the porcupine quoted in "Group Psychology and the Analysis of the Ego" I cannot tell you.

I wonder if this is any help to you.

Yours sincerely,
Anna Freud

The passage in *Group Psychology and the Analysis of the Ego* reads as follows:

> Let us keep before our eyes the nature of the emotional relations which hold between men in general. According to Schopenhauer's famous simile of the freezing porcupines no one can tolerate a too intimate approach to his neighbor.

A footnote tells the Schopenhauer parable:

> A company of porcupines crowded themselves very close together one cold winter's day so as to profit by one another's warmth and so save themselves from being frozen to death. But, soon they felt one another's quills, which induced them to separate again. And now, when the need for warmth brought them nearer together again, the second evil arose once more. So that they were driven backwards and forwards from one trouble to another until they had discovered a mean distance at which they could most tolerably exist.
>
> Paerega und Paralipomena
> Part II, 31, "Glerchinisse und Parablen"

Ernest Jones' biography of Freud gives an explanation of Freud's quest for the porcupine:

> It was there, [Putnam Camp] that, greatly to Freud's satisfaction, they sighted a wild porcupine, on which incident hangs a tale. He had made the interesting observation that when faced with an anxious task, such as the present one of describing his startling conclusions to a foreign audience, it was helpful to provide a lightening conductor for one's emotions by deflecting one's attention to a subsidiary goal. So, before leaving Europe he maintained that he was going to America in the hopes of catching sight of a wild porcupine *and* to give some lectures. The phrase "to find one's porcupine" became a recognized saying in our circle. Having achieved his double purpose, he was ready to return home.

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book REVIEWS

James Jackson Putnam and Psychoanalysis. Edited by Nathan G. Hale, Jr. 384 pages. Cambridge: Harvard University Press. $14.00.

"You convince me," wrote Freud, "that I have not lived and worked in vain, for men such as you will see to it that the ideas I have arrived at with so much pain and anguish will not be lost to humanity."

Putnam, Freud, James, Jones, Ferenczi, and Prince . . . Letters exchanged as if their authors awaited inscription in a copybook of history, and expected review by their successors. One is witness, and even, with surrender to the abandon of imagination, participant in the nurture of a movement relegated in its own time more to the province of psychic investigation than medical practice. This collection of letters recalls the zest of these debates and revives the spice of figures now historical, but once very much alive.

James Jackson Putnam was an aristocrat, an American Hegelian, and an essential moral idealist. Named after James Jackson, his maternal grandfather and one of the founders of the Massachusetts General Hospital, he attended Boston Latin School, Harvard College, and Harvard Medical School. After receiving his M.D. in 1869, Putnam left for Europe to study neurology. He heard Meynert in Vienna, Hughlings Jackson in London, Charcot in Paris, and Virchow in Berlin. He

returned to the U.S. enthusiastic about the German method of careful laboratory techniques and demonstrable causes of disease. Putnam's first appointment, in 1872, was as "Electrician" at the MGH. By 1893, he had become Harvard's first professor of neurology, having in the interim both founded and presided over the American Neurological Association.

For the first ten years of his academic life, Putnam was opposed to psychotherapy. By 1890, however, he was commenting that some of his patients seemed to respond more favorably to psychological intervention than to somatic therapy, and he began to investigate hypnosis, and similar approaches to the psyche. Putnam drew on the Aristotelian conception of the Golden Mean in his definition of mental balance: to him — at this stage — it partook of an equilibrium of conscious and unconscious, of mental and of somatic processes leading to harmony. Putnam maintained that the patient must be taught to change his character, to better himself, and to accept his responsibilities in the light of expected social obligations. As for the process of psychotherapy itself, this was an elaboration of other neurological examinations, and an extension of Janet's cathartic confessions of traumatic memories.

In December of 1908, Putnam met Ernest Jones. Both men were surprised and quite pleased by their impressions of the encounter. These impressions were reinforced and extended when Putnam heard Freud lecturing at the Clark University series on psychoanalysis. So interested was Putnam that he invited Freud to visit the Putnam summer camp at Keene Valley in the Adirondacks. Freud accepted the invitation and went to the camp, accompanied by Jung and Ferenczi. "Everything is left very rough and primitive," Freud wrote home, "but it comes off." Putnam began to invest in Freud an emotional and scientific respect which was to characterize Putnam's championship of psychoanalysis until his death in 1917.

The correspondence between Freud and Putnam changed in tenor from cordial inquiry to fast friendship, and comprised protracted discussions on clinical matters, scientific thought, psychoanalytical politics, personal difficulties, and philosophical positions. Putnam sought and found in Freud a brilliant neurologist, the successor and the equal of Charcot and Janet. The psychotherapy which Freud taught revealed to Putnam a moral imperative: the unconscious had an implicit recognition for Good which the patient must learn to follow and to use in the establishment of a sense of values, and this sense of values would then become the end point of sublimation. "No patient," said Putnam, "is really cured unless he becomes better and broader morally, and, conversely, I believe that a moral regeneration helps towards a removal of the symptoms." This philosophy presented difficulties for Freud: "Our art makes it possible for people to be moral and to deal with their wishes philosophically. . . . Be as moral as you can honestly be and do not strive for an ethical perfection for which you are not destined."

In 1911, Putnam presented his position to the Psychoanalytical Conference at Weimar. It was not at all well received. The kinder remarks referred to his paper as a sort of "centerpiece," admired by all, but which none dared to touch. The reception of the paper carried over into Putnam's correspondences, extending a touch of cordiality over the previous warm enthusiasm of ideological exchange.

The letters in this collection reflect an interchange of minds and clashing temperaments discussing the pettiest details and the most far reaching ethical disputations. The scholarship evident in Nathan Hale Jr.'s commentaries is an elegant tribute to the intellects of the men whose letters he presents. In addition to the German texts of Freud's letters, Hale has included a remembrance of her father by Mary C. Putnam, a chronology of letters and events, and a careful index of the contents of the letters. The correspondence itself is beautifully annotated, and Hale's introduction alone would be worth studying.

Putnam lived the ideal which this biographical study documents — a quintessential of inquiry, of curiosity, of receptiveness to new methods and concepts. Hans Zinnser has perhaps best succeeded in describing such a life: "One type of intelligent occupation should in all intelligent cases, increase the capacity of comprehension in general; . . . it is an error to segregate the minds of men into rigid guild classifications . . . art and science have much in common and both may profit by mutual approach."

TEODORO F. DAGI, M.D.

COMMENTARY

Why Putnam Now?

It has been 54 years since James Jackson Putnam died. This issue of the *Harvard Medical Alumni Bulletin* contains my article, "Freud and the Porcupine," and Teodoro F. Dagi's review of Nathan Hale's superb new book, *James Jackson Putnam and Psychoanalysis*. Another excellent book by Nathan Hale was published last year: *Freud and the Americans, the Beginnings of Psychoanalysis in the United States, 1876-1917*. Hence, perhaps, the renewed interest in James Jackson Putnam, the first influential American psychoanalyst.

On September 23, 1971, a publication party for *James Jackson Putnam and Psychoanalysis* was held in the Minot Room at the Countway Library. Honored guests were the author, Nathan G. Hale, Jr., and Putnam's daughter, Dr. Marian C. Putnam, who wrote the Foreword to the book. Also present were members of the Putnam family; Mr. Richard J. Wolfe, Rare Books Librarian at the Countway; Miss Ann Orlov, social science editor of the Harvard University Press; and Mr. Murray Chastain, biomedical editor of the Press and manager of its Commonwealth Fund Book Program. Each person described his activities related to the creation of the book.

Letters between Putnam and Freud were collected by Dr. Marian C. Putnam and deposited for the use of scholars, in the Countway Library. The letters were brought to the attention of Professor Hale who had them translated. Erik Erickson later commented that these were the finest translations he had seen. Mr. Wolfe was the liaison between the Putnam family and Professor Hale who described his pleasure in finding a "historian's dream." The book is a result of the cooperation among a historically minded, medically oriented family, a dedicated rare books librarian, a great University Press, and a first rate historian.

The party also brought together others who were interested in Putnam's contributions. Among them was a second-year student, Russell Vasile who had written an honors thesis on Putnam while a student at Princeton. Mr. Vasile was encouraged to submit his paper, "James Jackson Putnam 1895-1910, From Psychodynamic Research to Freudian Psychoanalytic Theory," for consideration for the Osler Prize. The Prize is awarded by the American Association of the History of Medicine for the best paper by a medical undergraduate. Unfortunately, Harvard has been noticeably absent from the competition for many years.

Although the Harvard Medical Library had a basic collection on the history of psychiatry, and the Boston Medical Library held the finest collection on phrenology, as well as the papers of Dr. Morton Prince and Dr. Isadore Coriat, it was not until the amalgamation of the two into the Francis A. Countway Library of Medicine and the arrival of Mr. Wolfe in 1964 that a truly significant collection began to be acquired. The arrival of the Putnam papers in 1965-66 stimulated other exciting additions. A collection of books and manuscripts by and about Johann Caspar Spurzheim, founder of phrenology, including his journals, manuscript and reading notes, and nearly 100 letters are now part of the archives, together with material by Dr. Sandermann on the hospitalization and treatment of Friedrich Nietzsche. The early records of the Boston Insane Hospital, which later became the Boston State Hospital; a series of letters from the first superintendent of McLean Hospital, Rufus Wyman; early Carl Gustav Jung letters from the Fanny Bowditch Katz collection; and the papers of Maria Moeltke, an early Jungian lay analyst have also been acquired. The Countway is negotiating with the Bollingen and Wicks Foundations in the hope that it may become the official repository of Carl Gustav Jung material.

More recently, the papers of Dr. A. Warren Stearns, former dean of Tufts Medical School and an expert on forensic psychiatry, were donated. In addition, and by great fortune, the papers of Dr. Manfred Guttmacher of Baltimore, another prominent forensic psychiatrist were added, thus creating the basis for a fine forensic psychiatric collection. The Library also received the papers of Eugene Emerson, the first psychoanalytic psychologist in America, and the papers of Dr. Max Rickle, who introduced LSD into the United States.

Interestingly enough, the building of Countway Library's psychiatric archives has spurred parallel movements in other libraries. The Nursing Archives within the Special Collections Section of the Mugar Memorial Library at Boston University is an excellent example. The Archives were established early in 1966 for the purpose of collecting the books, manuscripts, and other materials that would preserve the history of the nursing profession. The Archives, open to scholars from all fields, contain source material for research and writing on nursing. In 1967, a supportive grant from the USPHS hastened the growth and quality of the collection. The Archives have the papers of such notable nurses as Pearl McIver, Theresa Muller, Eleanor Gregg, and Florence Nightingale. The outstanding collection has been dubbed "The National Repository for the American Nurse Association and the *Journal of Nursing*," making it the only national nursing archive in the country.

Putnam's life has stimulated yet another activity — a symposium entitled: Psychoanalysis, Psychotherapy, and the New England Medical Scene: 1894-1933. Using Boston focally rather than parochially, the Symposium will look at the intellectual and social forces surrounding the introduction of psychotherapy to better understand the broad ramifications of the movement. The steering committee, consisting of Dr. Sanford R. Gifford, senior associate in psychiatry at the Peter Bent Brigham Hospital, Mr. Richard J. Wolfe, Dr. Otto Marx of Boston University, and myself are planning the activities for the symposium, which is scheduled for the fall of 1972. (See later issues of the *Bulletin* for further information.)

Putnam's heritage continues at Harvard, stimulating the recent activity that has enriched many areas. Alumni interested in contributing historical materials, particularly in the psychiatric area, should send them to Mr. Richard J. Wolfe, Curator of Rare Books, Countway Library, Harvard Medical School, Boston, Massachusetts 02115.

George Edmund Gifford, Jr.
Instructor in Psychiatry and
Consultant to the
Historical Collection,
Countway Library

Mt. Harvard

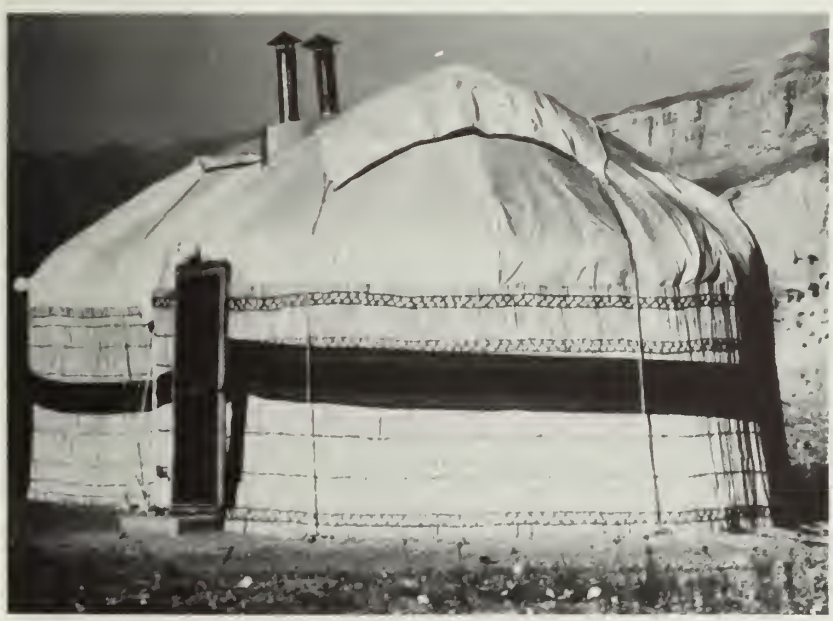
Stephen Arnon, a fourth-year student currently on leave completing a master's program at the School of Public Health, has been active in the Sierra Club since high school. Beginning with wilderness climbs in his home state of California, Steve pro-

Above: The Hindu Kush Mts. surrounded the village Steve and his group visited. The valley abounds with greenery and provides life support to many small, self-sustaining communities. *Left:* The women do much of the labor, and this 10-12-year-old girl is hauling wood. The men remain in the village caring for the children. *Below:* These boys are perched above some fine, old carvings. There are many children but the mortality rate is high and there are fewer teenagers.

Afghanistan

gressed at rapid rates. In 1970 he was asked by the Sierra Club to lead two small groups on a three-week trek through the Hindu Kush mountains of northeast Afghanistan. Steve has provided us with these photographs of his adventure.

Above: Upon reaching the top of the valley on their way to the mountains, the porters celebrated by playing musical instruments and dancing. *Right:* When not climbing mountains, the groups traveled in this bus. The roads were so bad they had to stop frequently to remove stones from the rear wheels. Here, the bus stopped beside two grave sites. *Below:* Steve snapped this picture of a yurt, a portable house usually occupied by nomads. It is made of carpets on a wicker frame.



Above: The climbers reached this 17,800 ft., previously unattained peak. Because Steve and one of his companions had done undergraduate work at Harvard, they dubbed the mountain, "Harvard." *Below:* For a breath-taking view of the valley, Steve climbed a huge statue of Buddha.

Letters

Editor's Note:

Because of the *Bulletin's* bimonthly publication schedule, we have decided to adopt the following editorial policy regarding letters to the editor. Letters pertaining to articles in the *Bulletin* will be published in the two consecutive issues following publication of the article. Letters received after this time will not be printed, but will be forwarded to the author of the article in question. Thus, if an article appears in the January-February issue, letters to the editor will appear in the March-April and May-June issues only.

Apologia

To the Editor:

I had looked forward with anticipation to the publication of "The Next Twenty-Five Years." Now I am ashamed to see my name on an homogenized version written in a style reminiscent of an honor grade high school theme, in which I am responsible for ideas to which I do not subscribe and for grammatical errors that I did not commit.

The *Harvard Medical Alumni Bulletin* ought to protect its authors by furnishing them with a final draft or proof whenever changes are made in a manuscript. In this case, I learned about the changes when I read the *Bulletin* and had no opportunity to protect myself.

It would be simple justice to publish in the next issue of the *Bulletin* the article in the form it was submitted. Failing that, it would be appropriate for the editor to publish, at the earliest opportunity, a note accepting responsibility for changes in the content and the style, and for the grammatical errors in the published version.

David D. Rutstein '34

Editor's Note:

The *Bulletin* respects what Dr. Rutstein has to say at any time and at all times. We are pleased to report that reprints of the article in its original form are available from Dr. Rutstein. We apologize to him for homogenizing his prose — the minions who were responsible have been duly punished. Let it be admitted, however, that we are in the business of journalism rather than *belles lettres*, and it may be that delicate suggestions made in nuanced phrases tend to become headlines in our hands. We aim, after all, to be reading matter for those who run.

The undersigned can even claim to being the victim of some of the same treatment. He will do what he can in the future to prevent the prose of a Macaulay or a Carlyle from becoming the language of the *Reader's Digest*. Meanwhile, of course, history is against us, and the next voice you hear may be that of a computer.

George S. Richardson '46

Lium's Article Stimulates Lively Exchange

To the Editor:

"Choice, Fees, and Quality" by Rolf Lium '33 deserves comment. He presents the liberal attitude albeit somewhat confusedly and confusingly. Perhaps we conservatives do not bother to present our views — laughing all the way to the bank.

I should qualify my remarks by stating that I am testifying, not arguing abstractions. I testify from 45 years experience, 28 as a solo general surgeon in a small city of 12,000, 85 miles from a large city in which I teach one morning each week in the department of surgery of the medical school.

Item I: Free choice of doctor by patient is only half the picture. Good medical care requires that I not be captive to my every patient. When the patient knows I have no choice but to attend him, our relation deteriorates significantly. . . .

Item II: Fee-for-service. I deny that it is incompatible with a total health service. I do not share Dr. Lium's opinion that V.A. hospitals provide excellent comprehensive care. His accusation of unscrupulousness is trite: Is any system of remuneration going to purge all the members of our profession of greed and laziness? The comparison of a teacher being paid for A students is insulting to the readers' intelligence. Actually, in this area, doctors are a tail of the dog. The sanctity of contract is pretty fundamental in human relationships.

Item III: "The doctor shall be the sole arbiter." A debater's purposeful malstatement? The proper statement is the physician shall be free to act solely in the interest of his patient. He should not be required to consider the interests of any third party. In these days and this context we are speaking in terms of the financial interests of a third party which too often are in conflict with those of the patient. A case in point: the politicians and bureaucrats have stupidly put themselves in the position of paying the bill for the old people. Naturally abuses of over-utilization are occurring. Mostly these are abuses by the patient, not the doctor. . . .

Dr. Lium laments the duplication of hospitals in Maine of Protestant, Catholic, and Osteopathic faiths. Is there no limit to the demands upon the medical profession?

Now we are blamed for and expected to resolve religious incompatibilities.

Item IV: "There is no evidence that by-passing fee-for-service and free choice of physicians has lowered the quality of medical care." My conversations with refugee physicians from England have convinced me to the contrary. Whatever the health delivery system in Sweden, I am sure that their doctors are less effective and the sick less well cared for in direct proportion to the extent to which there is interference in the free choice of patient and doctor, in the mutual satisfaction with the remuneration, and in the primary preemptive solicitude of the physician for his patient.

"Property rights?" Rights, surely, in the sense that to deny them is a great wrong, but to damn them with that liberal label is an ignorant misstatement.

THEODORE L. HYDE '27

To the Editor:

I must commend the Editors of the *Bulletin* for publishing the wise and forthright article on "Choice, Fees, and Quality" by Rolf Lium. Articles of this kind that gently air sensitive issues are particularly needed now as the debates over changes in our nation's health policies begin to shape up and intensify. I hope that the *Bulletin* will continue to present such timely and responsible articles so that we can all participate more knowledgeably, and hence more constructively, in the shaping and implementation of a National Health Program, whatever form it may ultimately take.

HOWARD N. JACOBSON, M.D.
Associate Professor of
Obstetrics and Gynecology
at Boston Hospital for Women

To the Editor:

Dr. Lium's article cannot be allowed to go unanswered. . . .

In attacking free choice of physician and fee-for-service, he overlooks the fact that most patients in this country do have the prerogative of seeking a physician of their choice and that most are able to pay for their medical care. . . . It may be significant that fee-for-service is not in effect at the very same institutional outpatient departments in which he feels medical care suffers.

I take great exception to the singling out of hospital-based physicians as monopolists. . . .

I take even greater exception to his comments on self-responsibility and quality of medical care . . . He seems to feel that there is a greater need for conformity in the present form of health care delivery in the community, than there is in the academic or government institutions where many of the medical and surgical staff are on the full-time salary basis. This claim is totally ludicrous. There must be total conformity within the academic atmosphere if one wishes promotions or an increase in salary, whereas in private practice, one has a much greater opportunity to express an opinion without fear of sanction from above. . . .

He suggests that the "participation of government in the planning and delivery of health services can have a beneficial effect" and that this should be discussed "without arising passions." . . . Dr. Lium not only arouses the deepest passions possible in the majority of physicians practicing in the tri-state region in which he is employed, but also preaches revolution instead of evolution. Certainly, the type of article which he has written is totally out of place for an individual in his position and he would do a far greater service if he "practiced what he preached."

MURRAY L. JANOWER
Chief of Radiology
St. Vincent Hospital
Worcester, Mass.

To the Editor:

In his article "Choice, Fees, and Quality," Dr. Lium suggests that the problem of delivering health care can be solved by eliminating fee-for-service, choice of physician, and instituting quality controls. His goal would be to "furnish service to everyone so that some professional person would be available to handle all problems pertaining to health in any area of the country." Certainly no one can argue with such an end but by what means will this be achieved?

He implies that all practicing physicians, within five years of completing training, are money-grubbing conservatives who will see and do anything to a patient to earn a fee. His answer is to place physicians on salary. But won't such self-serving individuals perform as little as possible once they are given a guaranteed income? We have only to look to our medical centers and their full-time staff to see that this is true. In fact, one of the reasons millions in this country do not get optimal care is that M.D.'s are not performing as anticipated. Instead of "furnishing a service" to everyone, they have full-time research or staff positions and see very few patients. Although they scorn fee-for-service as being selfish and amoral, they see nothing wrong with the growing number of hospital based physicians interested in non-ambulatory care, serving fewer and fewer patients, and caring little about their role vis-a-vis primary care for the population.

Moreover, it is my contention that physicians lose their idealism not after their training, but during it. It is from the medical center staff that they learn to think in terms of regular hours and rare disease in preference to "service to everyone."

But even if the physician who goes into practice preserves his ideals, he still must confront a population which is also fundamentally self-indulgent. As long as American society feels every ache deserves a pill and every fever a shot, any form of primary care is doomed to failure. The reasons patients call their doctor must be studied in depth if we are ever to solve the problem of adequate medical care. Yet this is not even discussed in Dr. Lium's article.

Finally, I feel it is important to note that the above thoughts are a summary of a much longer letter. I have complied with the editor's requirements, but I feel obliged to complain that the *Bulletin* rarely prints full articles presenting the view of busy practitioners who, although they may disagree vehemently with the AMA, are hardly represented by academic medicine.

IRA MARKS '59

To the Editor:

The excellent article by Dr. Lium proves that some of us who have reached our 65th year are still capable of thinking in terms of the changing economic picture of our country. His well expressed opinions, however, deserve some elaboration by one who has had more experience in private practice.

The idea that a patient should have free choice of physician is not necessarily advantageous to the patient's medical welfare. Patients who select their own physicians necessarily do so without adequate knowledge of the criteria whereby they may judge the physician's medical proficiency. . . .

Dr. Lium's criticisms of unsupervised chief of service standards are certainly valid, particularly in regard to his comments on monopolistic specialists. But his alternatives are not necessarily preferable. Salaried full-time physicians have an unfortunate tendency to be less concerned about individual patients and often the delivery of medical care becomes less efficient. The author's own example of the Veteran's Administration is an outstanding example of the inefficiency of medical care provided by a full-time salaried staff. . . .

The other alternative, a capitation system for payment, is likely to produce careless and hurried medical care because the physician is encouraged to keep his income as high as possible by seeing as many patients as possible in a given workday. Unfortunately, I believe that for the most efficient type of patient care, one will still have to use the fee-for-service concept even with government funded medicine and that fees will have to be controlled and supervised by individuals adequately educated for that responsibility. . . .

I should like to add a fifth provision to the four enumerated in Dr. Lium's "Bill of Rights." "A physician should be guaranteed the right to practice medicine according to the standard set by his peers without fear of unjustified and unnecessary malpractice action instituted by misinformed patients and venal attorneys." If the physician is to be an employee of the government, he should have the full protection of that government so that he can practice good medicine, not medicine influenced by fear of malpractice action. . . .

It is difficult for anyone to refute the belief that the practice of medicine will be taken over by the United States government within a relatively short time. . . . Our opposition can only delay what is best for the health of the American people.

THEODORE B. MASSELL '31

To the Editor:

The letter of the late Alden Squires '32 (see page 49) probably echos the feelings of many of us who are disturbed by the new curriculum and the current attitude of both administration and students concerning the training of a physician. The reply of Dr. Speigel certainly confirms Dr. Squires' characterization of certain vociferous students.

I, for one, protest the practice of turning over "a letter to the editor" to the subject of the letter writer's discussion and criticism allowing that person to reply in the same issue without giving the letter writer an equal opportunity to have "the last word." If the subject of a published letter wishes to reply to it, it should be on his initiative and not with editorial urging and advantage. Under the guise of fairness and efficiency, that is bias and discrimination in my opinion.

At the risk of being treated like Dr. Squires, I wish to express my views of Rolf Lium's article, "Choice, Fees, and Quality." Dr. Lium proposes to solve the medical problems of the entire population by government control "so that some professional person would be available to handle all problems pertaining to health in any area of the country." Apparently, he is not aware of the vagaries of human nature and the frustrations and freedom-destroying results of governmental control. To propose a "happy medium" of half bureaucracy seems equally naive. We are constantly bombarded with those frightening and equally deceptive statistics designed to show how foreign socialized medical care is superior to that available in the US. One can prove anything with statistics. I might use the same tactics to report those of recent surveys that have shown the low level to which medical care has fallen in many of the clinics of hospitals in large cities and medical centers and then point out how such medicine is regimented and not "free choice" care. In the final analysis, I wonder if Dr. Lium would take off for Sweden or the MGH if he were in need of medical care.

"Old Sayers" are not popular with socialists but there is an irrefutable "old saying" that "you can lead a horse to water but you can't make him drink." Anyone who has worked in an outpatient clinic can verify that many humans emulate our dumb animal friends. All men are born with equal opportunity but not equally endowed with genetic make-up. It would certainly be a dull world if they were. You can offer the best medical care in the world; you can chase after those who refuse to take advantage of it and even almost forcibly bring them in, but you can't make them follow directions, take medicines, keep appointments, return for treatment or follow-up. Only when they are sick enough to be annoyed or frightened will they appear for emergency treat-

ment and when the crisis is over, they fall back into the same pattern.

A recent study by Haggerty published in *Pediatrics* has shown that when you remove all the financial barriers to make the same medical care available to all, utilization by that group for which it was intended does not increase. There is another old saying that "you get what you pay for." Unfortunately, when anything is free, most Americans hold that thing in low esteem.

Finally, in "fantasy," Dr. Lium would top off his bureaucratic medical plan with a Bill of Rights for the physician that guarantees mediocrity and assures his medical care of the future will be on the same level. One could accurately substitute the term civil servant for physician in his "Bill of Rights." I certainly do not know the answers for the future best of medical care and I do not believe anyone else knows them either, but when you replace initiative and competition with regimentation and politics in any human endeavor, the caliber of its participants and the results are almost certain to deteriorate. I hope we will continue to improve on the quality of medical care and its delivery in a manner that will spare American medicine the mediocrity, inertia, frustration, harrassment, wastes, mistakes, and pure stupidity that emanates from an entrenched bureaucracy.

HARRY L. MUELLER '34

To the Editor:

Dr. Lium's article makes many points with which I would agree. Perhaps a better example of the fee-for-service system's failure is in the treatment of patients with chronic incurable diseases. In treating, on a large scale, patients with amyotrophic lateral sclerosis, I find that their need for attention, in terms of my personal time and energy, cannot possibly be recompensed by any of the existing public or private payment plans. It is only with the financial support of a private foundation that I can continue this work. My fee is derived in part from a fixed salary, and in part from fee-for-service charges from whatever insurance plan is available. . . .

But I am not sure that Dr. Lium has not overstated his argument when he states that Medicare and Medicaid have been catastrophic failures. As in Britain, with its national health scheme, no politician has had the courage to speak frankly to the public of the enormous cost of first-class medical care for everyone. . . . There is a vast reservoir of inadequately treated disease problems which are responsible in large part for the unexpected spiral of Medicare expenditures.

There is no avoiding the stark fact that for some conditions, medical care is very expensive, and I seriously doubt that all of the escalating Medicare expenses can be blamed on the avarice of private physicians.

FORBES H. NORRIS, JR. '55

Retirement Query

To the Editor:

I would like some means of learning how many Harvard graduates might be interested, on retirement, in having quarters in a "retirement home," such as is established for retired Navy and Army officers — a place having a library, recreation facilities, dining room, and medical care — where they could live with their wives. This is to be a nonprofit venture.

I would like to know whether the majority would wish such an establishment relatively near to New York and Boston, say within 100-150 miles, for instance, to permit club members to make use occasionally of their Harvard Club membership, or whether the majority would rather live in such a "home" situated, say, in some part of Arizona.

THOMAS DIXON '29

Alumni interested in such a venture may write Dr. Dixon at Ship Street Circle, Thomaston, Me. 04861.

Closer to Home

To the Editor:

I have recently had the opportunity to visit the practice of Larry Keith '52, a classmate of mine. He has been practicing in the South Chicago urban area since he left residency, and though his practice has changed little from its unbelievable load of multinational patients at the rate of 80 or more per day, it is still in the upper 50's. Besides all this, he now is associate professor at Rush Medical School and is the only pediatrician in an area of about a million people! In the articles which have appeared in the *Bulletin* concerning medicine in countries "across the sea," I think you occasionally miss practices like his which are "across the tracks." I would hope you could get him to write an article recounting his experiences with the urban ghetto. He will be coming to his 20th reunion this year and I encouraged him to think about writing such an article as a "20 Year Report."

WILLIAM D. COCHRAN '52

To the Editor:

I am somewhat flattered by Willie Cochran's suggestion that my practice warrants any mention in the *Bulletin* because I do not consider it "unusual" or of enough general interest to our alumni. It probably is not representative of a predominantly Black community in geographical location or in people served. My practice is, however, unusual in that I, as a Black pediatrician, serve a population which probably is not predominantly Black.

With your permission, I would be happy to submit an article in the future relating to my practice.

LAUREL E. KEITH '52

Editor's Note:

The Bulletin looks forward to receiving such an article from Dr. Keith.

VOTE

for

THREE CANDIDATES

for

HARVARD MEDICAL ALUMNI COUNCIL

1972-1975

RETURN BALLOT TO: Alumni Office

Harvard Medical School, 25 Shattuck Street

Boston Massachusetts 02115

BY 12:00 NOON

FRIDAY, MAY 26, 1972

JESSE ELDON THOMPSON '43A

Dallas, Texas

B. A. (University of Texas) 1939

1943-1944	Intern to Resident Neurosurgeon, Massachusetts General Hospital
1944-1946	Neurovascular Center, Ashford General Hospital
1946-1947	Chief, Neurosurgical Section, Walter Reed General Hospital
1948-1949	Resident Surgeon, Massachusetts Memorial Hospitals
1949-1950	Rhodes Scholar
1950-1954	General and Vascular Surgeon, Boston
1954-	Private Practice of General and Vascular Surgery, Dallas
1968-	Clinical Professor of Surgery, Southwestern Medical School
1968-	Chief Consultant in Vascular Surgery and Attending Surgeon, Baylor University Medical Center

Diplomate: American Board of Surgery. Fellow: American College of Surgeons. Member: Texas Surgical Society (President, 1972); Board of Governors, American College of Surgeons; The Society for Vascular Surgery (Treasurer, 1970—); American Heart Association, Council on Cardiovascular Surgery; International Cardiovascular Society; American Surgical Association; International Society of Surgery.

RAQUEL EIDELMAN COHEN '49

Newton Centre, Massachusetts

B. S. (San Marcos University) 1943

1959-1960	Chief of the Day Hospital, Massachusetts Mental Health Center
1960-1963	Senior Staff, MMHC
1963-1967	Psychiatric Director, North Suffolk Mental Health Center
1967-	Associate Director, Laboratory of Community Psychiatry, HMS
1968-	Fellow, Center for Community Health and Medical Care, HMS
1971-	Chairman, American Psychiatric Association Task Force on the Mental Health of Spanish Speaking Populations
1971-	Associate Psychiatrist, Massachusetts General Hospital
1972-	Associate Professor of Psychiatry, HMS

Fellow: American Psychiatric Association. Member: World Federation for Mental Health; Peruvian Psychiatric Association.

DANIEL DAVID FEDERMAN '53

Belmont, Massachusetts

A. B. (Harvard College) 1949

1953-1955	Intern to Assistant Resident in Medicine, Massachusetts General Hospital
1955-1957	Clinical Associate, National Institute of Arthritis and Metabolic Diseases
1958-1970	Research Fellow to Assistant Professor of Medicine, HMS
1958-1966	Clinical and Research Fellow to Assistant Physician, MGH
1964-1967	Chief, Endocrine Unit, MGH
1966-	Associate Physician, MGH
1967-	Assistant Chief of Medical Services, MGH
1970-	Associate Professor of Medicine, HMS
1970-	Associate Dean of the Faculty of Medicine for Continuing Education, HMS

Diplomate: American Board of Internal Medicine. Fellow: American College of Physicians. Member: American Society for Human Genetics; The Endocrine Society; Alpha Omega Alpha.

JOHN CLAVON NORMAN '54

Cambridge, Massachusetts

A. B. (Harvard College) 1950

1954-1955	Intern, Columbia Presbyterian Medical Center
1955-1960	Assistant Resident, CPMC
1960-1961	Resident, Bellevue Hospital
1960-1961	Assistant in Surgery, Columbia University
1963-1964	Thoracic and Cardiovascular Resident, University of Michigan Medical Center
1964-1969	Instructor to Assistant Professor of Surgery, HMS and Boston
1964-1969	City Hospital
1964-	Director, Cardiovascular Division, Sears Surgical Laboratory, BCH
1966	Markle Scholar
1969-	Associate Professor of Surgery, HMS

Diplomate: American Board of Surgery; American Board of Thoracic Surgery. Member: American College of Surgeons; Society of University Surgeons; Society of Thoracic Surgery; American Society for Experimental Pathology; American Physiological Society.

WILLIAM WEBSTER SOUTHMAYD '68

Fort Dix, New Jersey

A. B. (Harvard College) 1964

1968-1970	Intern and Third Assistant Resident in Surgery, Massachusetts General Hospital
1970-1972	Captain, U.S. Army Medical Corps
1972-	Resident in Orthopedic Surgery, M.G.H. and Children's Hospital

Member: National Association of Residents and Interns; Harvard Varsity Club; Harvard Club of Boston.

ROBERT ALLAN GUYTON '71

Boston, Massachusetts

B. S. (University of Mississippi) 1967

1971-	Intern in Surgery, Massachusetts General Hospital

Member: Phi Kappa Phi; Omicron Delta Kappa; Alpha Omega Alpha.

Alumni Notes

1912

Eliot S. Cogswell has retired from active medical practice after 57 years. He informs us that he feels less spry as time goes on.

1914

Austin W. Cheever is enjoying retirement and invites any classmates traveling in Honolulu to look him up.

1917

Frank B. Berry was guest editor of the *Bulletin* of the New York Academy of Medicine in November, 1971.

Karl A. Menninger reports that the kind reception to his book *The Crime of Punishment* has encouraged him to get to work on another. This one will deal with transgression and its consequences. Meanwhile he has also completely revised *The Guide to Psychiatric Books* in English, and with Phil Holzman, M.D., has revised his *Theory of Psychoanalytic Technique*.

Kemp P. Neal is completely retired and enjoying good health at Myrtle Beach, South Carolina.

1918

Eric P. Stone continues as part-time consultant for the New Hampshire Division of Public Health, and works chiefly with nursing homes. "Systems Education, Inc." will publish a monograph titled "Medical Records in Nursing Homes," written by Dr. Stone.

1919

Joseph Garland writes: "Generally retired!"

1921

Robert W. Buck writes: "It's rapidly getting to the point where if any of us can stand up and say 'I'm still alive,' it's news."

Maxwell E. Macdonald is still in active practice.

Denver M. Vickers writes: "Retired! And enjoying it very much."

John C. Whitehorn reports to his classmates that he received the Salmas medal of the New York Academy of Medicine "for distinguished service in psychiatry."

1922

Joseph Goldman is enjoying self-assessment studies initiated at the Beth Israel Hospital. He writes that he is constantly trying to keep abreast of the new and exciting advances in medicine.

1924

Panos S. Dukakis tells the *Bulletin:* "I feel fine. Still keeping busy except for obstetrics."

Irving A. Farrell sends his best to the class of '24, and adds that he enjoys good health.

Robert R. White, Jr. is still active in the practice of gynecology. He informs us that he has two surgeon sons: one in urology, the other in general surgery. Both are in their prime.

1925

Robert R. Baldridge has remarried. He and his new wife have 19 grandchildren!

Francis P. Twinem is still practicing urology, but tells us he has not been working quite as hard as before.

1927

Samuel H. Epstein is still in active practice of both neurology and psychiatry with two offices. One in the Back Bay and the other in Quincy. He also teaches neurology for HMS at Boston City Hospital.

Howard B. Hunt will be awarded the gold medal of the American College of Radiology at the annual meeting of the College in 1972.

John B. Sears made his second trip to Russia to attend meetings of the International Society of Surgery and the

International Cardiovascular Society in September. Dr. Sears co-chaired the meeting of the latter society, and reports that the best paper was given by Jesse E. Thompson '43A. Following the trip to Russia, Dr. Sears visited Turkey and Greece.

1930

Robert B. Aird has received many honors. A Distinguished Service Award from the Northern California Chapter of the National Multiple Sclerosis Society; an honorary membership in the Association of British Neurologists and the San Francisco Medical Association; and he had a building named after him at Deep Springs College in May. He adds that he has retired from the University of California, but still has an office there, and is busy as ever.

Alexander S. Dowling has retired as medical director of Chronic Disease Hospitals of Maryland and will assume part-time work as consultant to Montebello State Hospital and Social Security Administration.

J. Worden Kane writes: "Retired from practice of neurosurgery. Hope to catch up on other interests, and spend a longer time on our Cruiser.

William B. Nevius retired as the examining physician for the Children's Aid and Adoption Society of the Oranges, after serving them for 27 years. Dr. Nevius writes: "It was estimated that I had supervised the growth and development of 6800 children in that time. I felt very much honored when they named the clinic at the Society the William B. Nevius Clinic." He adds that he and his wife spent their summer vacation in Hawaii, and have acquired a small retreat in Lake Wales, Florida for future use. They spent nearly a month at the Highland Park Club there this winter.

Harry M. Spence writes: "(1) Have just completed nine years as Board of Regents, American College of Surgeons. (2) Currently president of Clinical Society of Genito-Urinary Surgeons."

Philip H. Wheeler was presented the Community Service Award from the state of Vermont at the Tri-State Medical meeting of the Quebec, New Hampshire, and Vermont medical societies last May.

1931

Charles H. Bradford writes: "Same as always — a little skeptical about always."

John S. Donaldson retired from practice of orthopedic surgery. Now he is a field representative for the American Medical Association.

Walter E. Garrey is back to full-time work after having a bilateral "total" hip joint replacement. The synthetic joints work beautifully, he reports. He and his wife spent six weeks in East Africa, on a self-planned photographic safari.

In September, 1971, **Harold Kelman's** book *Helping People: Karen Horney's Psychoanalytic Approach* was published by Science House in New York. It was the selection of their book club and has been favorably received. He continues as Dean of the Specialty Training Program in Psychoanalytic Medicine at the Postgraduate Center for Mental Health in New York. He presented an annual seminar in psychoanalysis in Stockholm, Sweden last summer.

Benedict F. Massell received a medal of honor and an honorary membership in the Brazilian Academy of Medicine. He was also made a consultant to the Federal University of Rio de Janiero in recognition of his scientific contributions to the problems of rheumatic fever and rheumatic heart disease.

Frederick H. Shillito has retired to professor emeritus at Ohio State University College of Medicine and assumed his duties as medical director of Columbus Research Laboratories, in Battell Memorial Institute, on a part-time basis. He added that all was going well.

Paul A. Younge was elevated to the honorary staff of the Boston Hospital for Women, and still practices gynecology during his summers in New Hampshire. He spends time with his children and grandchildren, now numbering four, when he can.

1932

George H. Marcy issues an invitation to alumni traveling to the reunion through Buffalo. He will be delighted to put you up and show you Niagara Falls.

Americo Savastano was appointed to the State Board of Regents for Education by the Governor of Rhode Island.

1934

Benjamin Alexander writes the *Bulletin:* "Still enjoying. Finding out more and more about less and less. New

York still a "fun city" in many respects. Biggest insane asylum, dog latrine, and 'parking area' in the world. Daughter Judith '70 interning in Denver; son Millard, Ass't Prof. Chem. Physics, University of Maryland; son Robert graduating U. of Wisconsin. Wife Marie still trying to teach people what to eat."

Frederick M. Anderson is still practicing general surgery in Reno. His son will be going to medical school next year.

David Freedman just completed his term as president of the Providence Medical Association and reports that it was a most interesting year.

Lewis L. Huston continues active practice, and has been blessed with two grandchildren. He says he "is taking longer vacations."

Lawrence E. Putnam addressed the 15th Annual Joint Educational Conference of the Food and Drug Law Institute in cooperation with the Food and Drug Administration in Washington, D.C., on December 7th. His subject was "The Package Insert: Implications for Physicians."

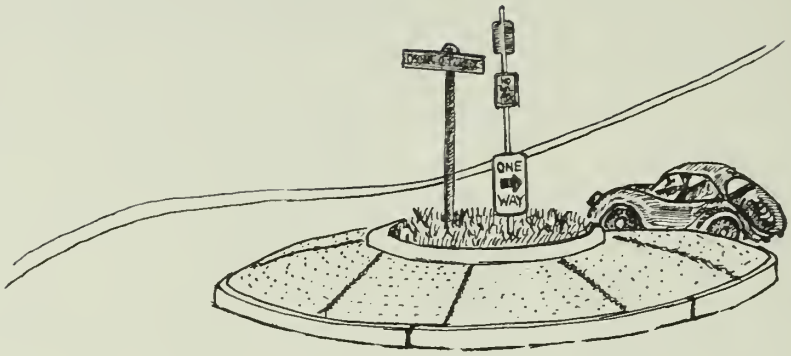
1935

John V. Cunney still enjoys surgical practice in his old home town, Salem, Mass. He says that HMSers are well represented in the fine community hospital.

1936

After ten years at Northwestern, **Robert B. Lawson** has moved to Miami where he is chief of staff at Variety Children's Hospital, and clinical professor of pediatrics at the University of Miami.

Paul C. Zamecnik writes: " 'Actuality is a running impoverishment of possibility' — Updike."



1937

Glidden L. Brooks is president of the Medical College of Ohio at Toledo.

1940

Edward J. Palmer is a neurosurgeon at the V.A. Hospital in Togur, Maine and is living "happily ever after, thank you!"

1943A

Ben Eiseman was promoted to Rear Admiral, M.C.USNR and was visiting professor at the Harvard Unit at Boston City Hospital during 1971.

George E. Hale took John Schilling '41 fishing in Alaska last summer. He wrote the *Bulletin* that they flew to their various sites. He also adds that he was elected to the board of governors of the A.C.S.

Logan O. Jones warns other 43A grads to beware, he may be dropping in on them. He is taking three to six months off work to look around for a new type of practice in a new area.

Paul H. Pfeiffer writes the *Bulletin:* "While in Boston recently, enjoyed a CPC at the General very much when **Edward P. Richardson, Jr.** said: 'There is no differential. There is only one thing this can be.' And he was so right. ME. is for Muskie."

Benson B. Roe writes: "1. Abandoned house and garden for cliff dwelling on Russian Hill. 2. Appointed to six-year term on American Board of Thoracic Surgery. 3. Elected to presidency of Society of Thoracic Surgeons."

We congratulate **Jesse E. Thompson** on his election as president of the Texas Surgical Society for 1972.

1943B

Christopher T. Bever's son graduated from Washington University in St. Louis last summer, and entered Rochester University School of Medicine in the fall.

Elmer V. Kenneally gave up his practice in Franklin County, Massachusetts and moved to Newfoundland to work full time. He started an eye clinic in the Central Newfoundland Hospital in Grand Falls. His son, David, assists him as technician, and they find the work rewarding and the needs of the province great.

Frank G. MacMurray writes: "Aging happily in Washington. Son Mac, 27, and his wife are Peace Corps volunteers in Chile. Lolly, 26, and her husband are school teachers in Boston. Worth, 17, is hoping to get into some college, preferably with the added distraction of girls."

Joseph E. Murray received an award for distinguished achievement from *Modern Medicine* in January for "early and continuing contribution in establishing kidney transplantation as a generally acceptable and effective procedure."

John R. Rydell is now chief of staff at Cottage Hospital in Santa Barbara. His oldest son, John 2d, is in his first year of law school at the University of Virginia. Another son, Jim, is at the University of Miami and his daughter, Alice, is at the University of Colorado. He writes: "The California schools are really not that bad!"

Warren T. Vaughan, Jr. has completed a year as president of the Northern California Psychiatric Society. Dr. Vaughan was also appointed chairman of the Committee on Community Child Psychiatry of the American Academy of Child Psychiatry.

1948

David L. Chamovitz and his wife traveled in the U.S.S.R. during October. Dr. Chamovitz writes: [we] "were struck by the bitter reality of Jewish existence there. I have been trained to direct my energies toward individual people, spending hours with an acute cardiac arrest. Now I must shift my order of priorities and concern myself with 3 million people."

Robert K. Fundhouser continues his Cambridge practice of internal medicine and his work in home care services at the Brigham. He adds that there is a new adult service at the Martha Eliot Clinic at Bromley Heath project that he enjoys working with very much. "The well organized use of paramedical and lay personnel from the community has much to teach me as a local practitioner," he writes.

Donald E. Love is still in Framingham practicing cardiology and internal medicine. He is active in a search for a new chief of medicine to replace Roger Hickler '49, who is now at the University of Massachusetts Medical School. He adds that he has five children in college, including a son in his first year at B.U. Medical School.

Clarence T. Thompson writes the *Bulletin* a succinct note: "Busy."

1949

Henry S. Harvey writes that his three children are grown and on their own. One boy, 15, still at home. He has seven physicians in a group practice, that is in need of a new wing in the building in Acton. He adds: "Suburbia, if not metropolis, engulfing us, so I can no longer call myself a 'rural' GP."

1954

James E. Cavanagh, Jr. spent August at Hôpital Albert Schweitzer in Haiti working in the surgical department. His two sons, Robert, 11, and John, 16, accompanied him and worked in public health.

Arthur J. Garceau informs us that his vineyard of French hybrid grapes is progressing well.

A. Bradford Judd is limiting his practice to half-time while he studies law.

J. Donald Ostrow is a part-time construction worker and redecorator in a big old Main Line house. He writes: "Lots of guest space for any who come to '76 Expo here. Still very happy at Penn. and involved in new interest in utilization of Physicians Associates."

Nanette K. Wenger was named full professor of medicine at Emory University School of Medicine. Dr. Wenger joined the Emory faculty in 1959, and she is supervising a study of sudden cardiac death and is evaluating the use of thrombolytic therapy in pulmonary embolism.

1955

Raymond Alexanian has been at the M.D. Anderson Hospital in Houston, Texas for seven years, as a hematologist emphasizing the care and study of patients with diseases such as myeloma, aplastic anemia, and the various polycythemias.

David S. Fischer asks: "Now that Yale Medical School has followed Harvard into the private practice of medicine with two separate pre-paid medical groups, would like to ask classmates who have worked with such, how they feel about them. Was it medically satisfying? Did patients get good care? I worked for H.I.B. for two years and the answers to my questions then were both NO."

James A. Greene, Jr. was promoted to full professor of internal medicine as of July 1, 1971. He moved to Kalamazoo to set up a nephrology unit in a private hospital. He adds that he is doing detection, medical renal disease, dialysis, renal transplants, and continuing his research.

Bernard Kliman writes: "This year has been one of discovery in my endocrine research projects, finding a new biosynthetic pathway, turning on dormant gonadotropin secretion with clomiphene, and quenching pituitary hypersecretion with the proton beam. In turn, more lectures and writing made time move so swiftly that I scarcely noticed major events such as promotion to associate professor, and a new NIH grant award. In retrospect, it was a most enjoyable year."

Richard C. Miller writes that the family is enjoying the South and that all is going well at the University of Mississippi where he is associate professor of surgery and engaged full time in pediatric surgery.

William A. Parshall spent two months in Viet Nam as a volunteer physician, and reports that it was a very interesting experience that has helped him to understand this complex problem.

1956

Robert M. Goldwyn has edited an 18-volume collection of books by physician-travelers over the past three centuries.

William E. Korndorffer, Jr. is director and pathologist for Rimmer Medical Laboratories, Inc.

Anthony P. Monaco spends 90% of his time in experimental and clinical transplantation.

1957

Harry L. Senger, Jr., a fine painter, exhibited his works at the Copley Society Gallery in December. Dr. Senger's work has also appeared at Jordan Marsh store shows, the DeCordova Museum, Springfield Museum, and at the National Academy of Design.

1958

Stephen B. Goodman writes: "I am enjoying medical practice in the Denver area. We spent three marvelous weeks in Europe this past fall."

John B. Livingstone writes that his wife and children are fine. He adds: "We are at zero population growth. Professionally very busy; we have developed a more effective method to help child psychiatrists and pediatricians collaborate in the delivery of child mental health services."

Walter E. Nance became secretary of the American Society of Human Genetics and was appointed to the NIH Genetics Training Study Section last year. He also served as a consultant in genetics to the World Health Organization and attended the fourth Congress of Human Genetics in Paris.

Rudolph W. Pierce received his MPH from Harvard in June after three years of part-time study and commuting from his private practice. He is now involved in inner city medicine with the Martha Eliot Center one day a week.

1959

Boyd R. Burkhardt continues plastic and reconstructive surgery in Tucson, and is anticipating the arrival of a partner this fall.

Joan Wareham Flacke works at Little Rock V.A. Hospital in anesthesia and research two days a week. She adds

that Chris (8), Gary (7), and Timothy (18 mo.) are keeping her hopping.

Robert A. Goldstone writes: "Summer found us at our new watering hole, in Cape Cod's Truro (surrounded by psychiatrists). Classmates needing sun, sailing, tennis, liquid refreshments, or sleeping accommodations (first come, first served, on the latter) will be welcome. As a result, our first daughter, Susan Jane is a citizen of the Commonwealth. A further result was my reconsidering the obvious necessity of obtaining a pilot's license to shorten the distance from New Jersey. This was accomplished in the early summer, and I expect to have my commercial and instrument ratings by the summer coming. In the meantime, I was appointed assistant clinical professor at Cornell University Medical College and at New Jersey College of Medicine and Dentistry (orthopedics)."

Neil H. Raskin writes: "Alexis Leigh, born on March 31, 1971, and the rest of us continue to enjoy San Francisco."

Joseph J. Schildkraut received the Hofheimer Prize for Research from the American Psychiatric Association.

1960

C. John Chacko writes: "Government controlled medicine is taking over by leaps and bounds. Facing the choice of becoming civil servant or leaving Canada in next few years."

Carl W. Norden is head of infectious diseases and associate professor of medicine at the University of Pittsburgh. He adds that he is thoroughly enjoying his new home.

Mark G. Perlroth sent us an amusing note: "Finally bought a house, have a son, passed my boards, not necessarily in that order. Am teaching medicine and cardiology at Stanford. See a good deal of **Rex L. Jamison, John M. Salzer,** and occasionally, even **Melvin C. Britton.** Regards to my friends.

Gordon F. Schwartz is presently associate professor of surgery at Jefferson and directs the surgical training program as well as all undergraduate surgical education. He bought a house in Haverford Pa., and reports that he is enjoying the Philly area, so plans to stay for a while. He adds: "Son Amory now amongst 10, daughter Susan amongst 6."

1961

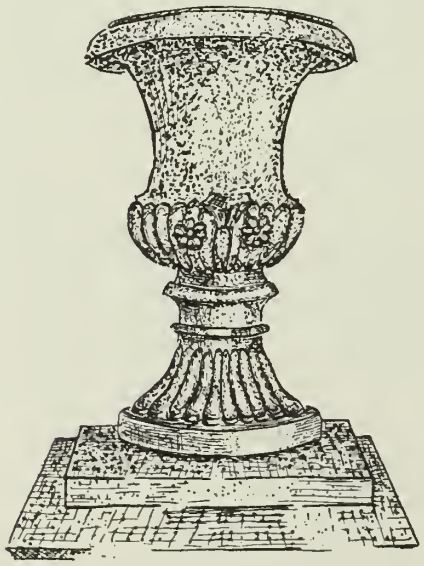
Peter S. Liebert writes: "I have given up the security of a full-time salary in the surgery department at Jefferson for the 'independence' of private practice. I continue to teach there and to serve as a member of the admissions committee. Phyllis and I had the pleasure of seeing **Clarence Zimmerman** at the recent Philadelphia meeting of the Association for Academic Surgery. He didn't ask for money then!"

James C. Parkes is practicing orthopedics at Roosevelt Hospital in New York City and teaching at Columbia University P&S.

1962

Jack B. Greenwell, Jr. began practice in general surgery at the Honolulu Medical Group in August.

Roger E. Meyer has been flying the Boston-Washington commuter flights once and twice weekly for the new Special Action Office for Drug Abuse Prevention which operates out of the Executive Office of the President. "This is the first time in 50 years that physicians and scientists have had major policy making responsibility in this area, which law enforcement formerly considered within its own exclusive purview." Dr. Meyer adds that in November, he changed his academic location from Boston University to Harvard as associate professor of psychiatry at Boston City Hospital. In March, Beacon Press published his book: *A Guide to Drug Rehabilitation: Public Health Approach.*



Anita Paine Vance announced the arrival of a daughter, Lisa Joy, on Jan. 3. Dr. Vance will continue private practice and her work at Mass. Mental Health in a few months.

1965

John L. Carmody has completed his surgical residency at the Harvard Surgical Service at Boston City Hospital. He will spend the next two years skiing, hunting, and fishing in Montana, at Malmstrom Air Force Base. Dr. Carmody reports that his wife, Judy, and their three children are all well.

Charles S. Langston continues on at the MGH as an angiographer. His wife, Debbie, has begun a practice of ophthalmology in Quincy, "so at least one of us is seeing patients!"

Michael M. Stewart is still on assignment to Ramathibodi Hospital in Bangkok, Thailand. He is a staff member of The Rockefeller Foundation there and invites any "itinerant HMS '65" to visit, especially if they would like to give a lecture or seminar!

1970

Michael I. Bennett and Evelyn Thal were married in August of 1971. Dr. Bennett is a medical resident at Presbyterian St. Luke's Hospital, and will be spending next year as a psychiatric resident at Beth Israel Hospital back in Boston.

Woodward Cannon is presently in first year residency in surgery at M.G.H. His wife, Helen, is working part-time in pediatrics at Cambridge Hospital. Their second daughter, Theresa, was born on December 21st and is thriving. They send us a compliment: their first daughter, Christy, is already reading the *Bulletin*. She is 14-months-old!

John A. K. Davies writes: "Alice and I are enjoying the company of Laura, born Oct. 2. After finishing the U.C. first year general surgery residency, I will return to the M.G.H. orthopedics program."

Frederic E. Hyman took a surgical internship at Yale-New Haven Hospital, and is currently completing his first year of surgical residency at Roosevelt Hospital in New York City. He expects to begin active duty in the Navy in July, 1972.

DEATH NOTICES

Ewing Taylor, 1903. Died 24 November 1971 at Beacon, New York. Dr. Taylor is survived by his daughter, Eleanor P. Van Kleeck.

Charles D. McCann, 1911. Died 11 January 1972 at Brockton, Massachusetts. Surviving is his wife.

Irving W. Jacobs, 1913. Died 24 October 1971 at Santa Ana, California. He is survived by his wife.

Edward B. Sheehan, 1913. Died 9 February 1972 at Newton, Massachusetts. Dr. Sheehan was a staff physician at the Boston Hospital for Women and St. Elizabeth's Hospital. He was a member of the American College of Surgeons, the Massachusetts Medical Association, St. Luke's Guild, and the American Legion. Surviving is his son, Edward B. Jr., of Orlando, Florida; four daughters, Mary Elizabeth and Patricia of Newton Centre, Mrs. Lavinia Cheever of South Weymouth, and Mrs. Theresa Cunningham of Westbury, New York; ten grandchildren; and two great-grandchildren.

Henry H. Hun, 1918. Died 29 January 1972 at Albany, New York.

Howard B. Jackson, 1919. Died 6 February 1972 at Boston, Massachusetts. Dr. Jackson served on the staff of the Faulkner Hospital and the outpatient department of Massachusetts General Hospital while maintaining a private practice in Jamaica Plain for more than 50 years. He was a member of the Norfolk District Medical Society, Massachusetts Medical Society, and the American Medical Society. Dr. Jackson leaves his wife, Elizabeth P. (Robinson); a son, Howard B. of Sandwich, New Hampshire; two daughters, Mrs. Neil Mackay of Wellesley Hills, Mass., and Nancy Jane Jackson of Meredith, New Hampshire; and four grandchildren.

Hartwick M. Stang, 1919. Died 29 November 1971 at Eau Claire, Wisconsin. Dr. Stang is survived by his wife.

Willard A. Chipman, 1921. Died 30 November 1971 at Detroit, Michigan. Dr. Chipman is survived by his wife, Isabel, three children, eleven grandchildren, and one great grandchild.

Louis Wolff, 1922. Died 28 January 1972 at Boston, Massachusetts. Dr. Wolff was a clinical professor of medicine emeritus at Harvard Medical School and visiting physician emeritus at Beth Israel Hospital. He gained world recognition when he first described the condition that came to be known as the Wolff-Parkinson-White Syndrome, involving the diagnosis of a particular heart problem. He was active in teaching and research, and his numerous publications include a text on electrocardiography. He was a member of many medical societies and was past president of the New England Cardiovascular Society. He leaves his wife, Phyllis (Raftell); four children, Lea, Richard '50, Sarah, and Charles, all of Brookline, Massachusetts; and a brother Alexander, residing in New Haven, Connecticut.

Stanley S. Saunders, 1924. Died 24 October 1971 at High Point, North Carolina. Dr. Saunders was a veteran of World War I, and practiced on the staff of the High Point Memorial Hospital.

Archer L. Hurd, 1927. Died 10 November 1971 at Somers, Connecticut. Dr. Hurd is survived by his wife Lillian.

Ettore F. Carnigila, 1929. Died 23 October 1971 at Windsor Locks, Connecticut.

Edward W. Bulley, 1932. Died 29 December 1971 at Apple Valley, California.

Alden W. Squires, 1932. Died 30 September 1971 at Augusta, Maine. Dr. Squires had retired from his position at the U.S. Veterans Administration Center at Togus, Maine, where he served as chief of anesthesiology. Dr. Squires leaves his wife, Mariam, and three children, Mrs. Marian Little, John A. and Charles S.

Lucio E. Gatto, 1938. Died 9 December 1971 at New Orleans, Louisiana. Dr. Gatto was a clinical professor of psychiatry at Louisiana State University Medical School, and a retired U.S. Air Force Colonel. He was a member of the Military Order of World Wars and the Southern Psychiatric Association. He leaves his wife, Janice (Sedorchuk); three sons, David, Lucio E., and Jaffrey; two brothers; and a sister.

David Yi-Yung Hsia, 1948. Died 27 January 1972 at Chicago, Illinois. Dr. Hsia was professor of pediatrics and head of the department of pediatrics at Stritch Medical School, Loyola University. He spent two months as visiting professor of pediatrics at the University of Saigon Medical School. He leaves his wife, Jayjia; four children, David, Judy, Lisa, and Peter; and his parents.

David J. Vail, 1948. Died 21 October 1971 at Minneapolis, Minnesota. Dr. Vail was the director of medical services for the Minnesota Department of Public Welfare and was in charge of the state's mental health system. A constant supporter of the humane treatment of the mentally ill, his efforts were honored by the American Psychiatric Association when they commended Minnesota for attacking the dehumanizing factors of mental health care. He is survived by his wife, Joane, four sons, two daughters, his parents, and a sister.

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of moderate to severe intensity

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- **Comparable to codeine in analgesic efficacy:** one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
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- **Dependence rarely a problem:** during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- **Not subject to narcotic controls:** convenient to prescribe—day or night—even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

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Contraindications: Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

Warnings: *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Precautions: *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

Myocardial Infarction. As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Patients Receiving Narcotics. Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

CNS Effect. Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

Adverse Reactions: Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

Dosage and Administration: *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

Children Under 12 Years of Age. Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

Overdosage: *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

Treatment. Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®), may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

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Although he's promised to take it easy back on the job, you know he's going back to the same stressful circumstances that may have contributed to his hospitalization. Your prescription for Valium can calm him. Lessened anxiety and tension can help in decelerating his former pace. During the period of readjustment Valium helps quiet undue anxiety.

For moderate states of psychic tension, 5-mg or 2-mg Valium tablets *t.i.d.* or *q.i.d.* can usually provide reliable relief. For severe tension/anxiety states, the 10-mg tablets often produce desired results.

The most commonly reported side effects are drowsiness, ataxia, and fatigue. Until individual response is determined, caution patient against driving or operating dangerous machinery.

Valium® (diazepam)

For the tense cardiac patient who must be kept calm

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose™ packages of 1000.

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110